



1872 South Tamiami Trail, Unit A Venice, FL 34293
941.366.0801 | www.rightaccordhealth.com

SERVICE AGREEMENT for _____ (Client Name)

This agreement sets forth the terms of our engagement and the nature of our services to be provided and your responsibilities in connection with such services.

RIGHT ACCORD is a provider of non-medical, in-home caregiver and companion care to the elderly who require assistance with their daily living activities. You wish to engage us to provide a caregiver at your home during prescribed times mutually agreed upon in advance to perform certain tasks as more fully described below:

* Personal Care (bathing, grooming, etc)
* Light housekeeping
* Homemaker / Companionship

* Medication Reminders
* Laundry
Others:

* Meal preparation
* Shopping / Errands
Skilled Nursing

AGREED RATE

Our fees are based on the amount of **hours/days** worked plus out-of-pocket expenses. The agreed rate for the type of care requested will be \$ _____ per **hour** or \$ _____ per **packaged shift**. Live In shifts are billed per 24-hour daily rate according to Fee Schedule. Hourly rate automatically applies if caregiver not able to have enough rest for 12 hours at night.

If you choose to send the caregiver home before the end of the shift, please note the **FULL** shift will be charged for unless prior arrangement has been made. **PLEASE NOTE: Observed holidays, overtime and couples care are charged at time and a half.** We have the absolute right, without limitation or penalty; to stop all work in the event there are disputes and/or delinquent fees due us.

Service requirement: ☐ Personal Care ☐ Homemaker/Companionship

Commencement date: _____ Amount of hours per visit: _____ times per week _____

	MON	TUES	WED	THURS	FRI	SAT	SUN
Requested time							

Please provide adequate notice to RIGHT ACCORD should you need to change, increase or decrease these days/hours.

SERVICE DEPOSIT

In order to begin work and place a qualified caregiver in your home, we will require a service deposit of \$ _____. This deposit represents an estimate of our fees for the first **week** of service to you. This deposit will be held until service's are no longer required, at which time this amount will be refundable and credited against any unpaid invoices or fees due to us. Please note that an additional deposit will be required if services are changed to increase the hours.

BILLING

Weekly invoices will be sent to you both for services rendered and for costs incurred on your behalf. The amounts shown on these invoices shall be due and payable within 15 days from the date of the invoice. Billing will be for the agreed amount of hours/days as shown above. You will be notified when rates are changed. Overdue accounts after 30 days will be subject to interest and collection.

UPDATED January 2022



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NON-SOLICITATION AGREEMENT

You hereby agree not to privately or directly hire, solicit or request transfer with another home care provider any caregiver under the employ of Right Accord for at least one year after the employee leave the employ of Right Accord. In the event that you breach the terms of this agreement, you agree to pay the sum of \$15,000.00 to RIGHT ACCORD. This is a fair amount for the significant investment of time

and money to hire, train caregivers and maintain clients. Additionally, you agree to accept full employer responsibility for said caregiver. You further agree to indemnify and hold RIGHT ACCORD harmless, its officers and employees from any liability resulting from your chosen arrangement. In addition, you will be responsible for any costs, damages and legal fees arising from this case.

TRANSPORTATION

You authorize the use of your automobile, if applicable, for errands and incidental transportation in connection with our caregiver services. If you are the driver, you agree to carry insurance and a valid driver's license. We agree that our caregivers will be appropriately insured and licensed. Additionally, a mileage fee of fifty-eight cents (.585 cents per mile) will be added to your invoice if caregiver will be driving their own vehicle to use for your care.

CANCELLATION OF SERVICES

Either party may cancel this Agreement at any time with **72 Hours** advance notice to the other party in writing. This does not apply to emergency medical situations such as hospitalization. If services are interrupted in any way for vacations etc., you agree to give us two weeks notice.

We appreciate the opportunity to be of service to you and look forward to a long-lasting relationship. The foregoing is in accordance with our understanding and we hereby agree to its terms and conditions.

By: _____
Agency Representative Signature Client or Representative Signature

Date: _____ Client/Representative Name (Print) _____

PERSONAL GUARANTY (CLIENT /CLIENT REPRESENTATIVE)

I, _____, SSN - _____, residing at _____
_____ hereby personally guaranty the payment of all obligations to
RIGHTACCORD Private Duty-Home Health Care.

Deposit amount received \$ _____	Initials: _____
Check # _____	Cash \$ _____
	Date: _____



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I hereby agree to bind myself to pay on demand any sum, which may become due to RIGHT ACCORD.

This guaranty shall be a continuing and irrevocable guaranty and action may be taken against me for any non-payment without notice thereof.

I hereby consent to any modification or renewal of the agreement which is signed by me hereby guaranteed and I will be responsible for any interest, attorney's fees or collection costs which Company shall be obligated to pay.

This agreement is signed, executed and enforceable under the laws of Sarasota and Manatee Counties, Florida.

Signature: _____

Print Name: _____

Date: _____



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Intent to Receive Service

This is to certify that on the following date, RIGHT ACCORD Home Health Care will begin delivering the below specified care services.

Person receiving care: _____

Date of service: _____

Type of service(s): _____

Location service is to be delivered: _____

Service Schedule: _____

Rate per hour for service(s): _____

Responsible payer: ☐ Person receiving care: ☐ Other: _____

Email to receive invoices: _____

Payment method: Auto Debit ACH (Bank Account) Transfer –

Routing Number:

Account Number:

Online

By Mail – Address invoices must be sent: _____

With in 24 hours a New Client Agreement will be emailed to: _____

Once that agreement is signed and filed, an invoice will be delivered to the above specified destination for the first week of service. All further invoices will be delivered on a weekly basis and will arrive no later than 5:00pm Monday of the following week.

Client/Responsible Payer: _____ Date: _____

Agency Representative: _____ Date: _____

UPDATED January 2022



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ASSISTANCE WITH MEDICATIONS

INFORMED CONSENT

This is to advise you or your surrogate, guardian or attorney, that you may be receiving assistance with self-administration of medication from an unlicensed person.

"Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by RIGHT ACCORD Private Duty – Home Health Care, LLC and who has received training with respect to assisting with the self-administration of medication as provided by agency rule.

I, _____, request RIGHT ACCORD Private Duty - Home Health Care, LLC to allow an unlicensed person to assist with the routine regularly scheduled medication that is intended to be self-administered. This may include both legend and over-the-counter dosage forms, topical and ophthalmic forms, optic, nasal, solutions, suspensions, sprays and inhalers. I understand this does not include mixing, compounding, converting, or calculating medication dosages, preparation of syringes for injections or administer injections, administer medication through a breathing machine or nebulizer, medication by the way of tube or cavity, parenteral and irrigation preparations, rectal, urethral or vaginal preparations.

Name of Client/Surrogate/Guardian

Relationship

Signature

Date

Witness

Date

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TRANSPORTATION WAIVER OF LIABILITY

CONSENT FORM

Please be advised that RIGHT ACCORD Private Duty - Home Health Care, LLC screens Caregiver for home-care related matters only, not for transportation. Should you wish to agree with the Caregiver on transport arrangements, please complete, sign and date this document.

Transportation Consent and Vehicle Release

I/We authorize the use of my automobile, if applicable, for errands and incidental transportation in connection with caregiver services. I/We agree to carry insurance and a valid registration on the automobile.

I/We understand that RIGHT ACCORD Private Duty – Home Health Care, LLC does not provide insurance coverage under any circumstances for any damage to my automobile or other property resulting from a RIGHT ACCORD Caregiver using it.

RIGHT ACCORD Private Duty – Home Health Care, LLC, nor the Caregiver's, will be held liable for any injury to the client (including death) or to a client's property resulting from the use of an automobile operated by the Caregiver for transporting a client in either the Caregiver's automobile or the clients automobile.

If client's vehicle is not available for whatever reason, client will be charged **.585** cents per mile.

Name of Client/Surrogate/Guardian

Relationship

Signature

Date

Witness

Date

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PAYMENT FORM

DATE: _____

You can make your deposit and/or recurring payments by check or Credit Card. If you choose to pay by one of the following methods, please complete and return as soon as possible. CHECK ☐ CREDIT CARD ☐

Patient/Client Name: _____

Client Address: _____ Telephone #: _____

Representative Details: Invoice to be sent to: ☐ Client ☐ Representative ☐

Name: _____ Relationship: _____

Address: _____

Telephone #: _____ Email: _____

Credit Card Details:

Name on Card: _____

Card Type: Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

Card Number: _____ Expiration Date: _____ CVN: _____

Billing Address: _____
(if different from above)

I authorize Right Accord to debit my credit card weekly for invoices billed.

Client Signature

Representative Signature

Please Note: To secure immediate services, credit card details must be completed. Additional 4% Fee per Transaction

Return by email to
management@rightaccordhealth.com
or fax 941-366-0801

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Bank Transfer Authorization Form

I authorize _____ to electronically debit my bank account according
Business Name
to the terms outlined below. I acknowledge that electronic debits against my account must
comply with United States law.

Terms of billing:

- ☐ One time on _____ for the amount of \$ _____.
mm/dd/yy
- ☐ Starting on _____ and on the _____ of each month through _____
mm/dd/yy Day of the Month mm/dd/yy
for the amount of \$ _____.
- ☐ Starting on _____ for the amount of \$ _____ and accordingly thereafter per
mm/dd/yy
the terms in invoice(s) _____.

Customer bank account information:

Routing Number Account Number

Account type: ☐ Checking ☐ Savings ☐ Consumer ☐ Business

This payment authorization is to remain in effect until I, _____, notify
Customer Name
_____ of its cancellation by giving written notice in enough time for the
Business Name
business and receiving financial institution to have a reasonable opportunity to act on it.

Customer Signature Customer Printed Name Date

UPDATED January 2022

Client Assessment Form

Date:

First Name:	Middle Name:	Last Name:
Phone number:	Date of Birth:	Gender: Weight:
Email address:	Start of Service:	End of Service:

Address:	Billing address:
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Emergency contact/next of kin:	Emergency contact/next of kin:
Relationship: Date of birth:	Relationship: Date of birth:
Phone number: (h) (c)	Phone number: (h) (c)
Email address:	Email address: fdgd

Supervisor:	Ambulatory: YES ☐ NO ☐
Referred by:	Client type: Private Pay by client: ☐ Private pay by other: ☐ Insurance company: ☐
Physician Name:	Physician address:
Phone number(s):	Fax number:
Principal Diagnosis/Medical History:	
DNR: YES ☐ NO ☐	

MEDICAL HISTORY:

ALZHEIMER's ☐ ARTHRITIS ☐ BLIND ☐ BP ISSUES ☐ BREATHING ISSUES ☐ CANCER ☐ CHRONIC PAIN ☐ DEMENTIA ☐

DIABETES ☐ FALLS ☐ HEARING ISSUES ☐ HEART ISSUES ☐ INCONTINENT ☐ MEMORY ISSUES ☐ PARALYSIS ☐

SPEAKING ISSUES ☐ STROKE ☐ TREMORS ☐ VISION ISSUES ☐ WOUNDS ☐ OTHER: - ☐

Assessed by: (print name)

Date:

MOBILITY ☐ INDEPENDENT ☐

Assist with ambulation ☐ Assist with transfers ☐ Bed/Chair only ☐ ROM exercises ☐ Standby assistance ☐

VISION LOSS ☐ NOT APPLICABLE ☐

Right eye ☐ Left eye ☐ Peripheral only ☐ Wears glasses ☐ Clean glasses ☐ PARTIAL VISION LOSS ☐

HEARING

Hard of hearing ☐ Wears hearing aid ☐ Is deaf ☐ NOT APPLICABLE ☐

DIET

Normal ☐ Diabetic ☐ Low Sodium ☐ Liquid only ☐ Feeding assistance ☐ INDEPENDENT ☐ Meal preparation: Breakfast ☐ Lunch ☐ Dinner ☐

BATHING ☐ INDEPENDENT ☐

Partial ☐ Complete ☐ Tub ☐ Shower ☐ Sponge bath ☐ Sink ☐ Other: ☐ A.M. ☐ P.M. ☐

SKIN CARE

Moisturizer ☐ Powder ☐ INDEPENDENT ☐

HAIR CARE ☐ INDEPENDENT ☐

Wash and dry ☐ Wash and set ☐ Brush and comb ☐

ORAL CARE

Brush and floss ☐ Denture care ☐ INDEPENDENT ☐

NAIL CARE ☐ INDEPENDENT ☐

lean ☐ File ☐ care ☐ plish ☐

SHAVING

Face ☐ Axilla ☐ Legs ☐ Electric razor ☐ Safety ☐

INDEPENDENT ☐**DRESSING**

Self dress ☐ Help select clothes ☐ Assist with dressing ☐

WEIGHING

WEIGHING ☐ INDEPENDENT ☐ Weigh client ☐ Frequency ☐

TOILETING

Bathroom ☐ Span ☐ Ur ☐ mmode ☐ c ☐ ge diapers

INDEPENDENT ☐**TRANSPORT**

Has own car for caregiver use ☐ Drives self ☐ Unable to drive ☐ Use of Caregiver's car ☐ Transport Waiver on file ☐

ASSISTANCE WITH MEDICATION

Yes ☐ No ☐ Assistance with Medication Informed Consent ☐ on file

HOUSEKEEPING

None ☐ Light ☐ Normal ☐ Special Instructions: ☐

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FUNCTIONAL LIMITATIONS

AMPUTATION	☐		PARALYSIS	☐		LEGALLY BLIND	☐
INCONTINENCE	☐		ENDURANCE	☐		DYSPNEA	☐
CONTRACTURE	☐		AMBULATION	☐		OTHER LIMITATION	☐
HEARING	☐		SPEECH	☐		DESCRIPTION:	☐

ACTIVITIES PERMITTED

COMPLETE BEDREST	☐		PARTIAL WEIGHT BEARING	☐		WHEELCHAIR	☐
BEDREST BRP	☐		INDEPENDENT AT HOME	☐		WALKER	☐
UP AS TOLERATED	☐		CRUTCHES	☐		NO RESTRICTIONS	☐
TRANSFER BED/CHAIR	☐		CANE	☐		OTHER	☐
EXERCISES PRESCRIBED	☐			☐		DESCRIPTION:	☐

MENTAL STATUS

Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic ☐ Other: _____

PROGNOSIS

☐ POOR ☐ GUARDED ☐ FAIR ☐ GOOD
☐ EXCELLENT

DME and SUPPORTIVE DEVICES: YES ☐ NO ☐	SAFETY MEASURES: FALL PRECAUTIONS	PETS?: YES ☐ NO ☐ CAT ☐ DOG ☐ TYPE: _____
NUTRITIONAL REQUIREMENTS:	ALLERGIES: YES ☐ NO ☐	SERVICES REQUESTED:

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SPECIAL INSTRUCTIONS:

Assessed by:

Signature: _____
(Assessed by)

Date: _____

Authorized by:

RN Name: _____
(printed)

RN Signature: _____
(signature)

Date: _____

MEDICATION RECORD

Client Name: _____

Date: _____

Physician Name: _____

Name: _____
(recorded by)

Please list client allergies:

DRUG NAME	DOSAGE	FREQUENCY	ROUTE

RN signature: _____

Date: _____

DRUG NAME	DOSAGE	FREQUENCY	ROUTE

Authorized by:

RN signature: _____

Date: _____



Telephone: 941.366.0801 Email: management@rightaccordhealth.com
Address: 1872 South Tamiami Trail, Unit A Venice, FL 34293

LONG TERM CARE INSURANCE INFORMATION

CLIENT INFO:

CLIENT NAME: _____

CLIENT ADDRESS: _____

TELEPHONE: _____

DATE OF BIRTH: _____ SS# _____

DESIGNATED POWER OF ATTORNEY: _____

LTCI INFO:

(LTCI) LONG TERM CARE INSURANCE COMPANY: _____

LTCI ADDRESS: _____

LTCI TELEPHONE: _____ LTCI FAX: _____

POLICY NUMBER: _____ CLAIM # _____

ELIMINATION PERIOD: _____

DAILY OR WEEKLY HOME CARE BENEFIT: _____



Tel: 941-366-0801

Visit our website:

www.rightaccordhealth.com

Email at:

management@rightaccordhealth.com

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"Serving Sarasota & Manatee Counties"

HHA299993655 ● HCS39965638

SCHEDULE OF FEES

Certified HHA/CNA

(Minimum 20 hours/week)

SUNRISE PACKAGE

\$230 (6 hours)

- Personal care morning routine
- Bathing, dressing, grooming
- Assistance with medication
- Toileting or incontinent care
- And more...

8:00 am - 2:00 pm

SUNSET PACKAGE

\$250 (6 hours)

- Assistance with dinner
- Medication Reminder
- Assist with bedtime routine
- And more...

3:00 pm - 9:00 pm

8 Hours and up - \$35 per hour
RN Visit - \$100 per hour | LPN Visit - \$65 per hour
LBK, Keys or Islands - \$40 per hour plus tolls, Weekends \$42
Care Coordination - \$75 per hour
Wellness Check in Service - \$150 per visit (up to 2 hours)
Assistance with Initial LTCI Claim - \$150
Short Term Case(less than 2 weeks of services): \$35/hour
Weekend Shifts - Add \$2/hour
COVID Rate - \$50/hour

Services offered:

- Personal Care
- Homemakers and Companions
- Sitters
- Few Hours to 24 Hours
- Live-in Care
- Skilled Nursing Care
- Staffing Services
- Case Management
- Facility Referral Services
- Personal Care and Assistance
- Errands and Transportation to Appointments
- Grocery Shopping
- Meal Preparation
- Light Housekeeping
- Medication Reminders
- Companionship
- CNA, Home Health Aides, Companion, Sitter
- Homemaker, Sitter
- Specialty Packages Available
- Employees are Certified, Insured and Bonded
- Criminal Background Checks
- Supervised and Case Managed by a Nurse
- Specialized in Dementia/Alzheimer's, Parkinson and Post Stroke Care
- Bathing, Dressing, Grooming, Toileting
- Walking and Transferring
- Assistance

Payors for Our Services:

- Long Term Care Insurance
- Veterans Aid and Attendant Benefits
- Medicaid Waivers
- Workers Compensation Benefits
- Private Trust Accounts - Private Funds
- Medicaid Waiver and Long Term Care



- Preferred Caregivers will be paid overtime and client billed overtime over 40 hours.
- Minimum 2 weeks of services required.
- Unused services are non-refundable.
- Deposit of one week home care services ordered is required before starting care.
- Payable by check, credit card or ACH.
- Ongoing payments are by ACH or Credit Card only. (Please fill out forms provided)
- Couples, overtime or major holidays will be billed at time and a half. Insurance cases- if holidays are not covered by the insurance company, client will be billed the difference.
- Mileage fee .585 cents per mile is charged when using caregiver vehicle.
- Merchant Fee of 4% added on all gross receipts if using credit cards.
- Caregivers who are sent home early will be billed a full shift as ordered or assigned.
- **Note:** If you decide to switch to another agency, no caregiver must be requested to change employment to the new agency for at least a year. No employee shall be hired or contracted by clients directly. A fee of \$15,000 will be billed to client if caregiver employed by this agency is contracted or solicited in any way to work with client.

Quick Care Package

PROTECTION FOR YOUR PEACE OF MIND

"RIGHT ACCORD QUICK CARE PACKAGE programs have been here every step of my journey. Being able to focus on what was important rather than what 'might be' gave me the ability to really live. Now that my care needs have increased, I don't have to worry about the next step because RIGHT ACCORD has already planned to take it with me." - T. Brown

Whether you are needing to ensure your loved one's well-being, recovering from a planned or unplanned surgery, or just the comfort in knowing someone will be coming by, **RIGHT ACCORD's Quick-Care Package** provides everything you need for a flat weekly fee of \$450 for In-Home Service (Monday - Friday at minimum 1-2 hours per visit).

TASK BASED CARE SERVICES:

- Flexible Hours (depending on caregiver location and availability)
- Medication Assistance
- Meal Prep
- Light Housekeeping
- Grocery and Care Related Errand Services
- Grooming
- Bathing
- Dressing
- Toileting and Incontinent Care
- Doctor's Appointments
- RIGHT ACCORD's Family Room Care Portal



For inquiries please call:

SARASOTA OFFICE:

(941) 366-0801

3900 Clark Road Suite B5
Sarasota, FL 34233

BRADENTON OFFICE:

(941) 487-3665

9040 Town Center Parkway
Lakewood Ranch, FL 34202

VENICE OFFICE:

(941) 366-0801

1872 South Tamiami Trail,
Unit A Venice, FL 34293

Schedule Builder

Contact Name: _____ **Client Name:** _____ **Date:** _____

Task	Circle Time (can choose more than one- circle all that apply)					Independent	Requires Assist.	Dependent
Wake up	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Coffee	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Dressing	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Morning Meds	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Breakfast	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
TV Program	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Noon Meds.	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Lunch	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Bathroom	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Showering	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Physical Activity	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Nap	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Social Engagement	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Snack	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Laundry	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Light Housekeeping	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Meal Prep.	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Dinner	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Evening Meds.	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Bathroom	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Change Clothes	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			
Bedtime	7am-9am <i>Other Times:</i>	9am-11am	11am-1pm	1pm-3pm	3pm-5pm			

Contact Name: _____ Client Name: _____ Date: _____

	SUN	MON	TUE	WED	THURS	FRI	SAT
SUNRISE PACKAGE							
9AM – 2PM							
SUNSET PACKAGE							
2PM-7PM							
Note: Weekend Requests will be dependent on Caregiver Availability and not guaranteed)							
8 HOUR SHIFTS							
8AM-4PM							
9AM-5PM							
10AM-6PM							
Note: Weakened Coverage is dependent on Caregiver Availability and cannot be guaranteed							
12 HOUR OR 24-HOUR SHIFTS							
8AM-8PM							
8PM-8AM							
7AM-3PM							
3PM-11PM							
11PM-7AM							
QUICK CARE PACKAGE (MONDAY-FRIDAY) <i>ILF/ALF and 55+ Communities ONLY</i>							
8AM-10AM							
10AM-12NOON							
2PM-4PM							
4PM-6PM							
6PM-8PM							

HIPAA – Notice of Privacy Practices

Due to the nature of our services, we may use related health information in order to provide proper services. RIGHT ACCORD Home Health Care is authorized to discuss medical information with family members, insurance representatives, social workers or other health care professionals. Whenever feasibly possible, we will do our best to protect our client's health information and keep identifying information private.

You have a right to request a restriction or limitation on the information we use or disclose about you for providing services, payment, and health care operations or to someone who is involved in your care. All requests must be in writing. Your signature below acknowledges acceptance:

(Patient Name)

(Client Authorized Signature)

(Date)

Assignment of Benefits

In certain circumstance it may be possible for RIGHT ACCORD Home Health Care to seek reimbursement directly from the insurance company. To alleviate client responsibility of filing a claim for payment, client authorizes RIGHT ACCORD Home Health Care to receive reimbursement directly from _____ (**Insurance Company**). This is called an "Assignment of Benefits." This is not a permanent assignment of benefits and will only be in effect during the period for which our staff is requested to provide services to you. **In the event the insurance company denies any claims, you, the client are ultimately responsible for payment of all invoices.**

If you elect to have the caregiver scheduled for more hours than the amount authorized by the Insurance Company, or if you elect to continue receiving care after the claim has been closed it will be your responsibility to pay for these additional services. We are required by NJ State Law to have a nursing assessment on the initial start of services and every 60 days or if a major change of health occurs. Regardless if we are able to bill the insurance company directly, you are responsible for signing a service agreement and providing a \$1,000.00 refundable deposit as outlined in our rate schedule prior to starting services. You, the client, are responsible for any RIGHT ACCORD Home Health Care service not reimbursed by the insurance company which could include: days not covered as part of an elimination period; exceeding the daily maximum benefit; holiday rates un-reimbursed; client requested hours above the amount authorized; client requested transportation services (\$.585 cents/mile from client location); and Nurse Services.

ASSIGNMENT OF BENEFITS: I _____ (**Client Printed Name**), authorize the assignment of benefits for payment of services provided by **RIGHT ACCORD Home Health Care**.

(Patient Name)

(Client Authorized Signature)

(Date)



RIGHT ACCORD

Private Duty-Home Health Care

1872 South Tamiami Trail, Unit A Venice, FL 34293

941-366-0801 | www.rightaccordhealth.com

Client Handbook Receipt

(please mail to office in envelope provided)

The Client Handbook describes important information about Right Accord. I understand that I should consult a Right Accord representative regarding any questions not answered in the handbook.

Information in the Client Handbook is subject to change. All such changes will be communicated through official notices and I understand that revised information may supersede, modify, or eliminate existing policies. Only the Owner of Right Accord has the ability to adopt any revisions to the policies in this handbook.

I have received the handbook and I understand that it is my responsibility to read and understand all of the information contained in this handbook and any revisions made to it.

Client Name: (printed): _____

Client Signature: _____

Date: _____

Right Accord Representative Signature: _____

Date: _____



1872 South Tamiami Trail, Unit A Venice, FL 34293
941-366-0801 | www.rightaccordhealth.com

FALL RISK ASSESSMENT

Client Name: _____

SOC: _____

- ☐ Gait disturbance (shuffling, jerking, swaying) – **4**
- ☐ Dizziness/syncope in an upright position – **3**
- ☐ Confused all the time – **3**
- ☐ Nocturia/Incontinent – **3**
- ☐ Intermittent confusion – **2**
- ☐ Generalized weakness – **2**
- ☐ “High Risk” drugs (diuretics, narcotics, sedatives, anti-psychotics, substance abuse, withdrawal) – **2**
- ☐ Previous falls within the last 12 months – **2**
- ☐ Osteoporosis – **1**
- ☐ Hearing and/or visually impaired – **1**
- ☐ 70 years old or greater – **1**

TOTAL = _____

A score of 1-3 points indicates a **LOW RISK of falling**

- Reassess fall risk every 3 months or as needed
- Give patient/family fall education brochure

A score of 4 points or more indicates a **HIGH RISK of falling**

- Implement ALL interventions below, as appropriate:
 1. Communicate patient’s fall risks to team members.
 2. Communicate patient’s fall risks to patient/family and provide fall Edu. Brochure.
 3. Encourage family participation in patient safety.
 4. Offer frequent toileting.
 5. Environment safety: avoid clutter in room, keep call bell and telephone near, leave door open, use a night light.
 6. Do not leave unattended on bedside commode or toilet.
 7. Use non-slip socks or shoes.
 8. Consult:
Pharmacist for possible medication interactions
Medicare Home Health for Physical Therapy for new mobility or ADL problems (MD Order Required)
 9. Use diversionary activities (diversion box) to prevent wandering.
 10. Order walker to assist with stability/walking.
 11. Wheelchair or chair for observation.
 12. Recommend 24hr care or obtain a sitter.
 13. Use a gait belt when ambulating.
 14. Other safety interventions.

Name and Title: _____

Admission Fall Risk Score: _____

Interventions (Circle) 1-7 8 9 10 11 12 13 14

Other: _____



RIGHT ACCORD

Private Duty-Home Health Care

1872 South Tamiami Trail, Unit A Venice, FL 34293

941-366-0801 | www.rightaccordhealth.com

Receipt of Privacy Policy Notice

I, _____, acknowledge that I have read and received a copy of the Privacy Policy Notice from Right Accord.

- ☐ I agree to allow Right Accord to call my Primary Care Physician to update him/her on the care they are providing for me in my home.

- ☐ I do not agree to allow Right Accord to call my Primary Care Physician to update him/ her on the care they are providing for me in my home.

Signature of Client or Authorized Person

Date

Witness

Date



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Notice of Privacy Practices

Notice of Health Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/ Information

Every time Right Accord makes a visit, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnosis, treatment and plan for future care or treatment. This information is often referred to as your health or medical record.

Your Health Information Rights

Although your health record is the physical property of health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of this notice of health information practices
- Inspect and obtain a copy of your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

This registry is required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duty and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

Communications With Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other



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person you identify, health information relevant to that person's involvement in your care or payment for health care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not rent or sell patient information. If a patient wishes to opt out of receiving further information, they may call us directly at 941.366.0801 or send written request to Right Accord located at 2831 Ringling Boulevard, Suite 121-F, Sarasota, Florida 34237.

Fund Raising: We may contact you as a part of a fund-raising effort. If you prefer not to receive Fund Raising Letters, please let us know by contacting our office directly.

Other Disclosures permitted without authorization and WITHOUT opportunity to agree or object:

Business Associates: There are some services in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, we require all business associates to properly safeguard your information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroner, Funeral Director and Organ Procurement Organization: We may disclose personal health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose personal health information to a funeral director as authorized by law in order to permit the funeral director to carry out their duties. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donations and transplants.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities relating to the oversight of the Registry.