JUL 30 2015

Attachment 3

PRIVATE DUTY SERVICES, INC.
Payment Agreement/Consent

PATIENT NAME:________________________________

PAYMENT AGREEMENT:

I am authorizing Private Duty Services, Inc., to submit invoices to:

____Passport or other Non-Medicaid Programs authorized by the contracted agency. The patient will have no financial liability to Private Duty for services.

_X_Patient or Responsible Person for the following service:

_____Homemaker/Companion at the rate of $____________per hr. at a minimum of 2 hr vst.
_____Personal Care Aide at the rate of $____________per hr. at a minimum of 2 hr vst.
__X__Additional $.65 cents per hr on wkends (11pm Friday until 11pm Sunday)
__X__Mileage for running errands at the rate of $ _________cents per mile
_____Time and ½ will be charged if request employee who is already working 40 hours/week
__X__Holiday's Will Be Billed at Time and One Half
__X__ Nursing at the rate of $ 32.50 per hour/visit

If billing patient/responsible person, send invoices to address below:

Name: Celina City Schools Address: 585 E Livingston St
Celina, OH 45822

Phone: ____________________

For refusal of service or no one at home when employee arrives at scheduled time, one hour may be billed to the above address.

Either party may terminate this agreement by 48 hours notice if under Private Pay Agreement.

The patient or responsible person understands that the employee has been placed in the home by Private Duty Services, Inc., and may not be hired directly by the patient or responsible person for a period of at least two years following the termination of contract with Private Duty Services, Inc.

CONSENT:

I verify that I have been a part of developing my Plan of Care. I understand that I will be advised, in advance, of any changes in my Plan of Care before the change is made.

I understand and have had explained to me conditions under which this agency is undertaking service to me and agree to accept these conditions.

I agree to receive homecare services as authorized by the contracted agency or as set up under private pay agreement. I have received a copy of this statement.

The projected visit frequency will be 5days/week per **. Services are subject to change based on the patient's needs, availability of staff and authorization of services.** school schedule

Patient or responsible person signature: Dr Keith J Schmitz **Date** 8/4/15

Nurse Signature: Deb Schmidt RN **Date** 7.23.15

***(Annual Renewal For Private Pay Clients Only)**

Pt's file – original / **Pt's copy** – yellow

Revised 7/15