



## CLIENT AGREEMENT FOR REFERRAL AND ADMINISTRATIVE SERVICES

This Client Agreement for Referral and Administrative Services (“Agreement”) is by and between ALIGN Homecare Inc. (“Registry”) and \_\_\_\_\_ (“Client”). The “Parties” means the Registry and the Client and, in the singular, refers to either of them, as the context makes apparent. The Parties agree as follows:

1. Nurse Registry Services. The Registry is a nurse registry licensed under Section 400.506, F.S. and offers referrals of care professionals who operate as self-employed independent contractors (“Caregiver” or “Caregivers”). The Registry conducts a background check for and verifies the professional credentials of each Caregiver before the Caregiver is eligible for referral to Registry Clients. The Registry also coordinates the provision of certain administrative services, including ongoing referral of Caregivers if requested by Client, billing and payment processing services, and certain other administrative services to facilitate Client’s receipt of care. The Registry provides no home care services and does not hold itself out to be a provider of home care services, as such services are exclusively rendered by the referred Caregivers. Client hereby engages the Registry to refer one or more Caregivers to provide home care services to Client.
2. The Registry Is Not the Employer of Referred Caregivers. **Client acknowledges and understands that the Registry is not the employer or joint employer of the independent contractor Caregivers and does not monitor, supervise, manage, train, or handle scheduling for Caregivers.** Should an employer of a Caregiver be deemed to exist, Client understands and agrees that Client may be found the sole employer of the Caregiver. When a Caregiver performs services for Client, Client acknowledges that the Caregiver performs such services solely on behalf of Caregiver, and not on behalf of or as an agent of the Registry. Client and the Caregiver are solely responsible for determining all aspects of their relationship, including the rate of pay for Caregiver’s services, the length of the engagement, and the care objectives. Client retains the right to accept or decline any referral and the right to negotiate directly with the Caregiver concerning all aspects of their relationship. The Registry has no right to interfere with such a relationship, other than to inform Client about a Caregiver’s background check and professional credentials and provide certain ongoing administrative services. The client acknowledges that the Registry has not made any assurance, guarantee, promise or representation with respect to the results and/or outcome of any services to be provided by Caregivers.
3. Registry Fee. Client agrees to pay the Registry’s fee for each hour of service provided to Client by a referred Caregiver (“Registry Fee”) during the term of this Agreement and pursuant to Section 10 below. The Registry Fee is separate from and in addition to the Caregiver’s fee. Client agrees to pay billing statements upon receipt and acknowledges that unpaid accounts will be considered in

default after thirty days, after which a default charge will be imposed at 1.5 percent per month, or the maximum legal interest rate, whichever is lower, on unpaid balances. Client agrees to pay the default charge, including all reasonable attorney fees and costs of collection. If the Registry institutes legal action to collect Registry Fees, the Registry shall be entitled to recover its legal fees and costs associated with instituting the action. Client assumes full responsibility for Registry Fees, irrespective of whether any portion of the charges for the Registry's or the care service is to be submitted to a third-party payor, including long-term care insurance. The client's account will be credited only when the Registry receives payment. This paragraph shall survive termination of this Agreement.

The client agrees to pay a \$\_\_\_\_\_ initial deposit. The Registry shall deposit this amount into an account separate from the Registry's operational funds and account. The Registry will apply the initial deposit to Client's last invoice for Registry Fees and any other unpaid balances owed pursuant to this Agreement then refund the balance, if any, to Client.

4. Billing Agent for Caregiver Payments. Client has requested that the Registry act as the billing agent for the services rendered by one or more referred Caregivers. Although the Registry may act as a liaison for negotiations between Client and Caregiver at their request, Client and Caregiver are responsible for determining the terms of their engagement, including the rate of pay for Caregiver's services. The Registry will attempt to refer one or more Caregivers within Client's preferred range of rates who also meets any other objective criteria specified by Client. If a Caregiver cannot be located to provide services within Client's preferred range of rates, the Registry will confer with Client about the market and the Registry's experience of typical pay rates in the area to serve as a benchmark for negotiations. Client understands and acknowledges that Client and a referred Caregiver can renegotiate the Caregiver's rate of pay at any time, and agrees to timely inform the Registry of any changes in the rate to ensure accuracy of payment. Client proposes the following range of rates for the services provided by a referred Caregiver:

- **HOURLY SERVICES** \$\_\_\_\_\_ - \$\_\_\_\_\_ per hour

Some Caregivers referred by the Registry require a premium payment of one and one half times their hourly rate of pay to provide services on certain holidays, typically New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas Day. If you need care services over a holiday, you agree to negotiate with the Caregiver about the potential payment of a premium rate for service hours logged on holidays and to notify the Registry of the agreed-upon rate for billing purposes.

Some Caregivers referred to by the Registry require premium payment of one and one half times their hourly rate of pay for providing services in excess of 40 hours per workweek. If you request coverage from a Caregiver who requires premium pay for providing services more than 40 hours per workweek, indicate whether you agree to pay that Caregiver's premium rate, plus the Registry Fee, for such services. Please note that the refusal to agree to premium payment for services provided more than 40 hours per workweek may reduce the number of Caregivers willing to provide services to you.

- I agree to pay a premium rate of one and one half times the Caregiver's hourly rate of

pay for any services performed more than 40 hours per workweek.

- I do not agree to pay a premium rate.

Client agrees to render payment for a referred Caregiver's services on a weekly basis upon receipt of a billing statement generated from Caregiver's Timecard, approved before submission by Client or Client's representative. The Registry will not review invoices for accuracy. Client's funds will be disbursed only as Client directs. Client understands that he or she is fully financially responsible to the Caregiver for charges billed for the Caregiver's services. If Client should fail to pay the Caregiver's fees in accordance with the terms of this Agreement, and it becomes necessary for the Registry, in its role as billing agent, to collect any outstanding balances through the judicial process or otherwise, Client agrees to pay costs of collection, including reasonable attorney fees. This paragraph shall survive termination of this Agreement.

The Registry will accept direct payment from Client's Long Term Health Insurance Company ("LTH") if Client assigns the payment of benefits to the Registry and the LTH carrier pays the initial claim and all subsequent claims within thirty days of billing. Client is responsible for any claims over thirty days old and any charges his or her LTH Carrier denies. This paragraph shall survive termination of this Agreement.

5. Indemnification Related to Caregiver Services and Vehicle Use. Client agrees to indemnify, defend and hold harmless the Registry and its officers, directors, members, employees, successors and assigns from any and all obligations, disbursements, losses, liabilities, deficiencies, penalties, interest, claims, damages, actions, proceedings, taxes, settlements, judgments, and costs and expenses (including reasonable attorneys' fees) arising out of, in connection with, or incidental to Client contracting with or employing referred Caregivers under any and all circumstances (including use of an automobile, regardless of ownership). This paragraph shall survive the termination of this Agreement.
6. Authorization for Physician Contact and Medical Record Information. Client gives consent for the Registry to notify Client's primary physician of the services provided to Client as required by Section 400.506(6)(b), F.S. Client hereby authorizes the Registry to view, furnish, obtain, and receive information from the medical record of the care recipient named in this document, including photographs or video taken of the care recipient, to any insurer, compensation carrier, health care facility, welfare agency, physician, or any health Caregiver for reasons of financial assistance or continuity of services. Regulatory and accrediting agencies also have Client's permission to review Client's service records. Personal health information will be kept confidential and will not be disclosed except for legitimate purposes stated in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.
7. Substitute Caregiver Referral. If Client initials this section, Client authorizes and directs the Registry to refer a substitute Caregiver in the event a Caregiver who provides services to Client is not available. Client understands that the Registry does not monitor or supervise Caregivers and that Client is responsible for notifying the Registry when a substitute Caregiver referral is requested. **Initials:**  

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8. Availability of a Registered Nurse. Client acknowledges that, when a CNA or HHA Caregiver is

referred, a RN is available to make visits to Client's home for an additional cost. Section 400.506(6)(c), F.S.

9. Direct Hire of Caregivers. Client understands that the Registry has made a large financial investment in screening and referring one or more qualified Caregivers to provide care to Client. Client agrees to pay a lump-sum fee of \$5,000.00 per Caregiver, plus any collection and litigation costs and attorney fees and costs charged to the Registry, if Client directly or indirectly hires any referred Caregiver outside of this Agreement during the time the Caregiver is providing services under this Agreement and for one year following the end of services being provided by the Caregiver. Client understands that he or she is free to directly contract with or employ such Caregiver and that the fees above are reasonable given the services provided by the Registry. This paragraph shall survive the termination of this Agreement.
10. Termination. This Agreement may be terminated by either Party at any time by providing the other Party with prior notice of its intent to terminate the Agreement. Termination of this Agreement shall have no effect on Client's engagement with a Caregiver, as the Registry has no right to terminate or otherwise interfere with Client's engagement with a Caregiver, other than to inform Client about matters pertaining to a Caregiver's background checks and professional credentials as required by state law. If Client terminates the Agreement and continues to receive services from a referred Caregiver, Client agrees to pay the lump-sum referral fee set forth in Section 9.
11. Entire Agreement. This Agreement contains the entire agreement between the Parties, and supersedes all prior agreements and representations, contracts, understandings, warranties, guarantees, inducements, or conditions, express or implied, oral or written, among the Parties with respect to such subject matter, except as contained in the Agreement. The Parties state and acknowledge that, by entering into this Agreement, they forego and extinguish any rights existing in any such prior agreement. No change or amendment to this Agreement shall be valid unless it is in writing and signed by both Parties.
12. Choice of Law and Enforcement. This Agreement shall be governed by the laws of the state of Florida, without regard to choice of law principles. Any litigation shall be brought in the state or federal courts located in or covering Miami-Dade County, Florida. Each Party agrees to the exercise of personal jurisdiction by such courts to the full extent permitted by law. This paragraph shall survive termination of this Agreement.
13. Severability. Should any term or provision of this Agreement be found invalid or unenforceable, the remainder of this Agreement shall not be affected, and each and every term and provision otherwise valid shall remain valid. This Agreement shall be binding upon, and inure to the benefit of, the Parties and their respective successors, assigns, and heirs.
14. Responsible Party. This section shall not apply if Client has not authorized a third-party to bear responsibility for Client's performance under this Agreement ("Responsible Party") and if Responsible Party does not execute this Agreement. In consideration of the Registry's services and the Registry entering into this Agreement, which the Registry would not do but for this guarantee, Responsible Party agrees to guarantee Client's prompt and faithful performance of all terms and conditions of this Agreement, including without limitation payment of all amounts owed by Client

to the Registry and/or to Caregivers. Responsible Party's obligations shall be co-extensive with Client's obligations under this Agreement and all modifications thereof. This guarantee shall be binding upon Responsible Party's legal representatives, successors and assigns. This paragraph shall survive termination of this Agreement.

**Client has read and fully understands the contents of this Agreement and agrees to its terms.**

Effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**ALIGN Homecare Inc.**

**Client or Legally Authorized Representative**

SIGNATURE

SIGNATURE

\_\_\_\_\_

\_\_\_\_\_

NAME

NAME

\_\_\_\_\_

\_\_\_\_\_

TITLE

DATE

\_\_\_\_\_

\_\_\_\_\_

DATE:

\_\_\_\_\_

**RESPONSIBLE PARTY**

SIGNATURE

\_\_\_\_\_

NAME

\_\_\_\_\_

DATE

\_\_\_\_\_

RELATIONSHIP TO CLIENT

\_\_\_\_\_



**NOTICE TO PATIENTS-YOUR RIGHT TO REPORT**

**Medicaid Fraud**

To report suspected Medicaid fraud, please call AHCA Medicaid Program Integrity toll-free at (1-888-419-3456) or the Attorney General toll-free at 1-866-966-7226.

**COMPLAINTS**

To report a complaint regarding services you receive, please call the Agency for Health Care Administration toll-free at 1-888-419-3456.

**ABUSE, NEGLECTFUL, or EXPLOITATIVE PRACTICES**

To report abuse, neglect, or exploitation, please call the Florida Department of Children and Families toll free at 1-800-962-2873.



## CLIENT CONFIDENTIALITY STATEMENT

ALIGN Homecare Inc. maintains a practice of confidentiality and protection of personal and medical information of the clients in our service. In order to provide the highest quality of service, there may be instances in which ALIGN Homecare Inc. , discloses information about you.

- Use and disclosure may occur when:
- A referral is made on your behalf, or to coordinate other appropriate in-home services. These may include a consultation with doctors, nurses, health care personnel, facilities and providers who specialize in health services/products.
- For the purpose of billing for services, ALIGN Homecare Inc. , may be required to release medical information to an insurance company or third-party payer.
- In order to maintain quality assurance for your service, ALIGN Homecare Inc. , may discuss your service needs with office and field personnel who provide services to you.
- Releasing information to family members and other individuals of coordination of services. Information may be released to the following:

Designated Agent, Power of Attorney, Conservator, Guardian, Family Members, Relatives, and/or Friends who have your well-being in their interest and also have the need for relevant serve information.

Is there anyone whom ALIGN Homecare Inc. , should/must not release information? If so, please name:

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- In the event of a medical emergency when the release of confidential information will benefit professionals providing services or care.
- When situations of abuse, neglect, exploitation, and domestic violence are identified, as required by law.



**PLEASE BE ADVISED OF THE FOLLOWING:**

- 1) The caregiver referred is an independent contractor and ALIGN Homecare Inc. , is not obligated to monitor, supervise, manage or train the caregiver.
  
- 2) R.N.'S are available to make visits to the patient's home for an additional cost.

**ALIGN Homecare Inc. Representative**

(Signature) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLIENT OR RESPONSIBLE PARTY**

(Signature) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**RECURRING PAYMENT CREDIT CARD AUTHORIZATION FORM**

CLIENT NAME: \_\_\_\_\_

**HERE'S HOW RECURRING PAYMENTS WORK:**

You authorize regularly scheduled charges to your Visa, MasterCard, and American Express. You will be charged each billing period (weekly) for the total amount due for that period for services rendered to the above-named client. A receipt will be emailed to you upon request and the charge will appear on your credit card statement. I understand and accept the following conditions:

1. Weekly charges will recur for as long as the services are rendered or until I give ALIGN Homecare Inc. written notice to discontinue automatic credit card billing.
2. In the event that my financial institution rejects charges to my credit card by ALIGN Homecare Inc. for any reason, I will pay the charges due immediately and no later than 72 hours after the rejection.
3. I agree to notify ALIGN Homecare Inc. immediately if there are any changes to my credit card.
4. I agree to address any disputed charges directly to the ALIGN Homecare Inc. office *before* disputing the charges with my financial institution.

**PLEASE COMPLETE THE INFORMATION BELOW AS IT APPEARS ON CARD (PRINT):**

I \_\_\_\_\_ authorize ALIGN Homecare Inc. to charge my credit card.

CC NUMBER: \_\_\_\_\_ EXP DATE: \_\_\_\_\_ SECURITY CODE: \_\_\_\_\_

TYPE OF CARD: \_\_\_\_\_ VISA \_\_\_\_\_ MC \_\_\_\_\_ AMEX

CREDIT CARD BILLING ADDRESS (PRINT): \_\_\_\_\_

TELEPHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ EMAIL: \_\_\_\_\_

SIGNATURE OF CARDHOLDER: \_\_\_\_\_

RELATIONSHIP TO CLIENT: \_\_\_\_\_

*I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. There is a credit card processing fee of 3%. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. This payment authorization is for the type of billing dictated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.*

Dade: 7855 NW 12<sup>th</sup> ST # 205 Doral, FL. 33126

305-773-8003



Client Requested Services

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Care Recipient (if other): \_\_\_\_\_

Street Address: \_\_\_\_\_ County: \_\_\_\_\_

Building/Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Community/Facility: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact Name/Relationship: \_\_\_\_\_

Emergency Contact Phone/Alternate Phone: \_\_\_\_\_

Responsible Party/Relationship: \_\_\_\_\_

Responsible Party Phone/Alternate Phone: \_\_\_\_\_

Responsible Party Billing Address: \_\_\_\_\_

Long-Term Care Insurance?  Yes  No

LTC Insurance/ Company Name: \_\_\_\_\_

LTC Insurance/ Address: \_\_\_\_\_

LTC Insurance/ Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Pets in the home?  Yes  No If yes, describe: \_\_\_\_\_

Do you smoke?  Yes  No

Emergency Telephone Numbers

Medical emergency: 911

## EMERGENCY MANAGEMENT & SPECIAL NEEDS REGISTRY

Client's/Patient's Name:

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Florida law requires nurse registries to maintain an emergency management plan, which must include a list of clients who need continued services during an emergency and/or assistance with transportation to a special needs shelter. *Section 400.506(12), F.S.* To help ALIGN Homecare Inc. in maintaining its emergency management plan, please answer the following questions:

1. Will the patient need continued care services during an emergency? *Section 400.506(12), F.S.*

Yes No

2. Will the patient need assistance in evacuating or being transported to a special needs shelter in an emergency due to any type of physical, mental, or sensory disability? *Section 400.506(11)-(12), F.S.*

Yes No

3. If yes, do you know if the patient is part of the special need's registry maintained by the county emergency management office? *Section 400.506(11), F.S.*

Yes No Do not know

Florida requires nurse registries to inform the patient or patient's representative of the special need's registry and, if the patient is not registered, advise of the procedures for registration and assist in registering, if applicable. *Section 400.506(12), F.S.; Rule 59A-18.018(6)(a), F.A.C.* Registries also must document the following information for patients who are registered or will be registered at a special need's registry.

4. If the patient is or will be registered at the special need's registry, does the patient plan to

evacuate from the home in the event of an emergency? *Rule 59A-18.018(6)(b), F.A.C.*

Yes No

5. If the patient is or will be registered at the special need's registry, during an emergency, can the patient's family or other person who provides care to the patient take responsibility for services normally provided by independent contractors referred by the registry? *Rule 59A- 18.018(6)(b), F.A.C.*

Yes No

6. If the patient is or will be registered at the special needs registry, will the registry need to make additional independent contractor referrals for services to continue during an emergency? *Rule 59A-18.018(6)(b), F.A.C.*

Yes No

If the patient will have other assistance during an emergency, please provide that person's emergency contact information:

Name: \_\_\_\_\_

Connection to patient/client: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Client or Responsible Party Name (Print):

\_\_\_\_\_

Client or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_



**Informed Consent for Assistance with Medications**

**CLIENT/PATIENT NAME:** \_\_\_\_\_

In accordance with the Florida Statute § 400.488, ALIGN Homecare Inc. hereby advises the patient, or the patient's surrogate, guardian or attorney in fact, that the patient may be receiving assistance with self-administration of medication from an unlicensed person, in connection with services received from the independent contractor Care Provider referred by ALIGN Homecare Inc. "Unlicensed person" is defined as an individual not currently licensed to practice nursing or medicine who is employed by or under contract to a Nurse Registry and who has received training with respect to assisting with self-administration of medication, as provided by the Agency of Health Care Administration. § 400.488(1)(b), F.S.

**PLEASE CHECK BELOW WHICH APPLIES:**

- I am capable of self-administering my own medication, do not require assistance, and will not ask assistance from any Care Provider referred by ALIGN Homecare Inc.
  
- I do require assistance with self-administration of my medication, and it has been explained to me that I may be receiving assistance with self-administration of medication from an unlicensed person in accordance with the Florida Statute (§ 400.488, F.S.) I have been given a copy of the Statute.

\_\_\_\_\_  
**Signature of Patient, Patient's Surrogate, Guardian or Attorney in Fact**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**



Date: \_\_\_\_\_

Dr.: \_\_\_\_\_

Address: \_\_\_\_\_

Dear Dr.: \_\_\_\_\_,

This is to notify you that ALIGN Homecare Inc. will be providing home care services to patient:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

The services are scheduled to begin on \_\_\_\_\_.

Please, do not hesitate to contact us with any questions or concerns.

Thank you for your attention.

Administrator

Dade: 7855 NW 12th St, Suite # 205 Doral, FL 33126  
Phone: 305-773-8003