

NEW MILLENNIUM HEALTH CARE INC

SERVICE AGREEMENT

Client Name: _____

Client MA Number: _____

Address: _____

Admission Date: _____

Emergency Phone Number: _____

Service Provided	Discipline	Description of Services To Be Provided	Frequency units/day	Unit Cost	Payer Source
	Nursing	Private Duty RN complex	units / day	\$9.91 per unit	
	Nursing	Private Duty LPN complex	units / day	\$7.44 per unit	
	Nursing	Private Duty RN shared care	units / day	\$6.20 per unit	
	Nursing	Private Duty LPN shared care	units / day	\$4.76 per unit	
	Nursing	Private Duty RN regular care	units / day	\$8.26 per unit	
	Nursing	Private Duty LPN regular care	units / day	\$6.34 per unit	
	Nursing	RN Skilled Nursing Visit	units / day	\$71.30 per	
	Nursing	RN Supervisory PCA Visits	units / day	\$7.00 per	
	PCA	PCA	units / day	\$3.98 per unit	

Services are billed on a bi-monthly, monthly, quarterly, bi-annual or annual basis.

Client Financially Responsible for Bill: Yes No

If No, and other than Medical Assistance then list the responsible parties name: _____

ASSIGNMENT OF BENEFITS

I request payment of any authorized health insurance benefits and hereby assign benefits payable on my behalf directly to New Millennium Health Care Inc. I understand that should payment not be made to New Millennium Health Care Inc, I will be responsible for services rendered to me.

I understand I will be responsible for : co-insurance deductible private pay none.

I understand that the charges for services reflect time for direct care, travel time, mileage reimbursement, time spent in contacting my physician, charting, written information to keep the doctor informed of my progress, supervision of cares and staff, care plan reviews, case management, care conferences, coordination with other services, medication and supply renewal, secretarial time, billing, maintenance of medical records, and for non-chargeable supplies and services.

I will be notified in writing at least fourteen days in advance of any change in charges or services.

AGENCY RESPONSIBILITIES

- ◇ Send qualified staff.
- ◇ Notify client of any changes in schedule, services, or fees.
- ◇ Have a representative available by phone 24 hours per day.

CLIENT RESPONSIBILITIES

- ◇ Notify office if need to cancel skilled visit or reschedule services at least 24 hours in advance to avoid charges.
- ◇ Pay agreed upon fee for services provided or arrange for payment to be made.
- ◇ Provide written cancellation notice to terminate package services two weeks advance.
- ◇ Contact the office immediately if you have a concern or problem by phone, email, or letter.
- ◇ To treat staff like the professionals that they are at all times.

CONSENT FOR CARE

The services to be provided to me by New Millennium Health Care Inc, staff have been explained to me. I hereby consent to the staff of said program to visit my home periodically to render home health care. I understand that the treatment plan and care plan may change and that such changes will be discussed with me. Instructions for my care will be explained to me and will become my responsibility in the absence of a home care staff member or my refusal of staff member in my home. Client also agrees to take full responsibility for their health / respiratory care and will direct others in my cares. If client chooses to leave home without a nurse or PCA client will take full responsibility for themselves, as well in the event that they want to be undisturbed in their room with door closed. In accordance with the above client promises not to hold New Millennium Health Care Inc responsible for any possible negative consequences or any accidents that might arise during this time. In case of any emergency I will call _____ for help. I also understand that if I refuse cares or have a significant health change my physician may be kept informed of my actions or change in status.

RELEASE OF INFORMATION

I authorize information in my medical record to be released to authorized representative of New Millennium Health Care Inc, Medicare, Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to New Millennium Health Care Inc on my behalf. I authorize my hospital, nursing home, physician's office or other health facility where I have been a client, to disclose any part or all of my medical record to New Millennium Health Care Inc. Also, I authorize the release of medical and other related information to social/health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by New Millennium Health Care Inc. I understand that my medical information will be shared with my physician, and staff, as appropriate.

MEDICAL EMERGENCY PLAN			
Advance Directive:	<input type="checkbox"/> Written information has been provided to client	<input type="checkbox"/> Client does not comprehend an Advance Directive question	
	<input type="checkbox"/> Client does not have Advance Directive	<input type="checkbox"/> Client has an Advance Directive	
Code Status:	<input type="checkbox"/> DNR/DNI	<input type="checkbox"/> Full Resuscitation	
Client has the following Advance Directives (check all that apply):			
	<input type="checkbox"/> Living Will	<input type="checkbox"/> Durable Power of Attorney for Health Care	
	<input type="checkbox"/> Mental Health Treatment Declaration	<input type="checkbox"/> Nomination of Guardian or Conservator	

I have been advised of my rights regarding advance directives. I have been provided with written information about the Agency's policies regarding Advanced Directives and information about my right to formulate Advanced Directives.

In the event of medical or situational emergency please contact:

_____ Home Phone: _____ Work Phone: _____
 _____ Home Phone: _____ Work Phone: _____

CONTINGENCY PLAN

Essential Services: If services are needed for medical or safety reasons and New Millennium Health Care Inc is unable to keep the appointment, New Millennium Health Care Inc shall make arrangements acceptable to the client and/or responsible person to complete services. Unless otherwise specified staff will continue to provide care until new staff arrives or until staff is physically exhausted at which time client will be transported to local Hospital for respite care. Specific arrangements are: _____

Emergency medical services will be summoned unless there is a physician signed DNR/DNI order on file

Non-essential Services: If New Millennium Health Care Inc is unable to keep a scheduled appointment that is not essential for medical or safety reasons, New Millennium Health Care Inc shall provide a replacement person or notify the client and reschedule the appointment.

Agency representative available 24 hours per day. _____

Special considerations involving client specific cares and needs.

- ____ **I have received a copy of the home care bill of rights.**
- ____ **I have received a copy of the written complaint procedure.**
- ____ **I have been informed that information regarding home care services may be shared with my physician**
- ____ **I understand that this contract to be in effect until terminated or renewed**

Home Care Nurse's Name: _____

 Signature (Client or Authorized Representative) Date

 Signature and Title of Witness Date