**Little Angels Home Care LLC** data……………………. **Ewa Grzymala** (owner)

**240 Myrtle Street, Shelton, CT. 06484**

**Phone: 203-278-1436 Fax: 203-513-7299**

**Client Consent and Financial Agreement**

Client Name……………………………………………………………………Client #.............................

Client DB……………………….. Phone #..........................................................................

Data when service will start …………………………………………………………………………………..

**Consent for Services**

I hereby authorize **Little Angels Home Care LLC** to render appropriate home healthcare services to the client name above. I understand such care will be provided by appropriate level health care personnel. I recognize and agree that the right to refuse treatment or terminate by notifying the office of Little Angels whit 2 weeks notices. The 2 week notice is waived if termination of services is upon dead of the patient. In addition Little Angels Home Care LLC may terminate services by notifying the client of termination and providing a reason. A one week notice of termination will be provided.

**Authorization for Emergency Medical Services**

At any time while under our care and in the event of any medical emergency I authorize Little Angels Home Care LLC or employees to obtain such medical treatment as they deem advisable under the circumstances (calling 911). I agree to assume the responsibility for all charge for such treatment .If a DNR is provided 911 will be called and the DNR will be provided to the medics.

**Release of Medical Records**

I hereby consent that copies, if necessary, of any prior medical records be delivered to Little Angels Home Care LLC to establish or continue any home care treatment plan. I hereby authorize Little Angels Home Care LLC to release copies of my medical records or reports or such portions or summaries which may be relevant to other health care providers, facilities ,or regulatory or accredited bodies for the purpose of continuing and coordinating my plan of treatment and quality assurance, survey and accreditation purpose.

**Notification of services and rates**

I acknowledge that I will be billed weekly for the cost of services provided every Thursday, (week ending on Sunday) . I understand that I am financially responsible for paying all fees related to care. I understand that I have to pay one week up to the front of services , if the case is ending and I pay more than I received services , the Agency will send me refund for services which I don’t received.

**Circle days of the week:**

Sun, mon, tue, wed, thu, fri, sat,

**Estimated days per week:** ………………………………………………………………………………………………………….

**Estimated hours per day ……………………………………………………………………………………………………….**

**Time of service…………………………………………………………………………………………………………………………**

**Rate per hour…………………………………………………………………………………………………………………………..**

**Rate per 24 hour care………………………………………………………………………………………………………………**

**Please circle : CNA, Home Health Aids, Live-in, Nights, Weekends, Hourly ,Companion, Homemaker,**

Aides providing 24h care will have meals provided by patient or patient representative.

**I understood that I can’t hired aids privately from this Agency which provide care now, means- Little Angels Home Care LLC aids or any aids provided by Little Angels Home Care LLC and now employed by another agency cannot be hired for a period of one year or will be face penalty of $6000.00(six thousand dollars)**

Signature……………………………………………………………………date……………………………………..

**We may be able work with third part payer**

I hereby authorize **Little Angels Home Care LLC** to bill for services payment directly from a third party payer source as a private insurance company. I understand that I am financially responsible for charge not covered by a third party payer source and that I am responsible for assisting Little Angels Home Care LLC in any way possible in collection efforts from third party payer sources. I understand that I am responsible for all charge including deductibles, insurance co payments and non covered services not paid after consideration of benefits by any and all payers at the time of verification. I certify that the information given by me is accurate and correct. If the insurance company should pay me directly I will immediately refund those money to Little Angels Home Care LLC .

I authorize Little Angels Home Care LLC to release all records required for payments.

Policy #..............................................................................................................

Name of insurance company…………………………………………………………………………..

Address to the company……………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………..

Phone #...............................................................

Fax #...................................................................

Payment to be made by:

Name of responsible party…………………………………………………………………..

Bill should be send to the following address: ……………………………………

……………………………………………………………………………………………………………

**Client Consent and Financial Agreement**

By my signature below:

I acknowledge that I have read and fully understand the provisions of the Client Consent and Financial Agreement and was given an opportunity to ask questions and voice concerns. I understand that the Agency may use or disclose health information about me to carry out treatment, payment or health care operation.

**Client Signature…………………………………………………………..Date**…………………………….

**Relationship to patient…………………………………………………………………………………………………………..**

**Patient Representative Phone #................................................................................................**

**Patient Representative Address……………………………………………………………………………………………….**

**City …………………………………………………………State………………………………………………Zip................**

**Little Angels Home Care LLC Signature………………………………………………………………………………….**

**OFFICE USE ONLY**

**Reviewed by: …………………………………………………………………………………**

**Approved by …………………………………………………………………………………..**