Patient Information

Date: __/___/____

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

Home Phone: _____ Cell: _____

Sex: ____ Marital Status: _____ Social Security: ____/___/_____

GUARANTOR INFORMATION

(List person or insured name responsible for bill)

Relationship of Guarantor to Patient: _____

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip code: _____

Home Phone: _____ Cell: _____

Email Address: _____

EMERGENCY CONTACT

Full Name: _____ Number: _____

Relationship to patient: _____

Full Name: _____ Number: _____

Relationship to Patient:_____

296 Flax Hill RD Norwalk CT 06854 +1 2039193545 christine@thecaringservice.com

SERVICE AGREEMENT CONTACT

The service agreement is made as of (date) ___/___/_____ by and between **A&C service LLC** and _____ hereinafter referred to as "I."

For the services that will be rendered by **A&C service LLC,** I understand that:

- This Service agreement will commence on ____/____/_____ and continue until terminated by either party.

- Beginning each week, **A&C service LLC** will confirm the scheduling of services for the week. Any change of the agreed upon schedule must be made through **A&C service LLC** and myself and not the caregivers.

- I agree to pay **A&C service LLC** for the services rendered at the following rates:
  $_____ per hour weekdays and weekends, for services of 6 hours or more.

- I will pay time and a half for services rendered on the following holidays:
  - New Year's Day 12am-12am
  - Memorial Day 12am-12am
  - July 4th 12am-12am
  - Thanksgiving Day 12am-12am
  - Christmas Day 12am-12am

- I assume responsibility for the payment of any and all sums that become due for the stated services including third party billings to my insurance company. **A&C service LLC** will not bill insurance companies for services rendered unless there is a prior authorization. If I decide to submit **A&C service LLC's** invoices to my insurance company for my reimbursement, I will instruct my insurance company to pay me, as I have already paid **A&C service LLC** for services.

- I agree that any scheduled shift that is cancelled without 24-hour prior notice, for reasons including family visits, hospitalization, client transfer or relocation, end of service and client expiration, will be charged the full shift.

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Payment options:

1. **Weekly Payment** The payment is per week. The billing cycle is on every Friday of the week. The first (1) week payment shall be due at the time of signing this Service agreement Contract and considered as the advance payment.

_____ (initial)

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