Assured Home Nursing Services
Caring for the Community

725 S. Adams, Suite 258
Birmingham, MI 48009
Ph: 248 593 8134
248 255 5870

SERVICE AGREEMENT

Client Name: _____

Address: _____ Social Sec #: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Business Telephone: _____

Date: _____ SOC Date: _____

Classifications and Rates: $_____ AM _____ PM _____ MN _____

********** Weekend Rates: AM _____ PM _____ MN _____

1½ times the standard rate for the following Holidays: New Year's Eve-Starting at 7pm, New Year's Day, Easter, Memorial Day, Mother's Day, Labor Day, Independence Day, Thanksgiving Day, Christmas Eve-Starting at 7pm and Christmas Day.
(Federal Law requires overtime for any hours worked in excess of forty per week)

A deposit of (2) full Weeks of services is required payable to Assured Home Nursing Services. This is applied to the first bill, and is refundable if the entire 2 weeks of service is not needed.

A minimum (4) hour shift twice a week, or a (8) hour shift once a week is required.

I, being of legal age, agree that I will assume responsibility for payment of any and all sums that become due for stated services including those not covered by insurance. These services are not covered under the Medicare program.

I give my permission of authorization personnel to perform requested tasks, procedures, or treatments as assigned for the delivery care. I also authorize Assured Home Nursing Services to request and/or release information from my health or service records for the purpose of payment, audit or review by authorized representative.

I further understand that my caregiver is an employee of Assured Home Nursing Services. Clients or families may not hire any of Assured Home Nursing Services personnel. If I violate this agreement, I agree to pay Assured Home Nursing Services $100,000 liquidates damages.

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Payment is due upon receipt of invoice. Interest will be charged on the unpaid balance of any invoice over 30 days at a rate not to exceed the legal maximum (annual rate of 18%).

Amounts not paid after 30 days will be considered delinquent and non-payment will jeopardize continued services.

All mileage will be billed at 55 cents a mile when transporting a client to various errands and appointments utilizing the staff's vehicle.

Charges for services are subject to change and the client will be informed in writing atleast 30 days before implementation of the charge.

I understand that Nurse Aides are only allowed to administer medications set up in a cassette

Billing Name: _____ Social Security#: _____

Billing Address: _____ Home Telephone: _____

City: _____ State: _____ Zip Code: _____

I authorize any family member, relative or friend who signs this agreement to act in my stead as my attorney in fact, and to perform all acts and undertake any obligations under this contract as I could do personally.

Any payment due Assured Home Nursing pursuant to this Service Agreement shall be binding against my heirs, executors and assigns, and shall be deemed an allowed claim against my estate, whether or not Assured Home Nursing files any proof of claim.

_____
Client Email

_____ _____
Client Signature Date

_____ _____
Nursing Supervisor Date

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The Undersigned personally guarantees payment of all expenses incurred under this service agreement.

Print Name: _____

Address: _____

Email: _____

State: _____ Zip Code: _____ Phone Number: _____

Social Security Number: _____

DOB: _____

_____

2 Week Deposit Amount

_____ _____

Signature Date

_____ _____

Nursing Supervisor Date