

Samaritan Services Inc.

Client Agreement

In consideration of the provision of private duty nursing services to be rendered by Samaritan Services Inc. for _____ I hereby give authorization and consent to Samaritan Services Inc. and its staff to render needed nursing care and other support services to the above named patient under the supervision of his/her physician.

I understand that the health care services rendered will be coordinated by a registered nurse and that care includes but may not be limited to skilled nursing and other therapies such as physical therapy, occupational therapy, speech therapy and social work as required, including referrals for paraprofessional services, such as certified nursing assistants, home health aides, personal care assistant or companion. I authorize all necessary records to be released to such providers to enable them to render services to me.

I understand that Samaritan Services Inc. will bill me on a weekly basis. Billing week is from Monday to Sunday. Payment for said services must be received within three (3) days of receipt of the invoice. The rate for service is \$_____per hour for CNA, HHA, PCA or companion. Payment should be made by money order, check or credit card.

I also understand that I am responsible for all payments for services rendered by Samaritan Services Inc. and upon request Samaritan Services Inc. will forward invoices to my insurance company.

I understand that I have the right to request that Samaritan Services Inc. replaces any employee whom I may deem to be unsatisfactory.

I also hereby authorize Samaritan Services Inc. and any credit bureau or other investigative agency engaged, to investigate the reference of other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Signature: _____ Date: _____

Relationship to Patient: _____
(If other than patient, explain why patient cannot sign)

Signature: _____ Date: _____
(Samaritan Services Inc. Representative)