Agreement to Establish Home Care Services

Patient Name: _____ Medical Identification #: _____ Date: _____

Consent for Medical Treatment: I consent to examination and treatments by Kaerbear's Healthcare, LLC (hereinafter "Kaerbear's"), including, but not limited to, any laboratory tests, blood samples, and intravenous medications ordered or prescribed by my physician. I have been informed of the nature, risks, possible alternative methods of treatment and possible complications involved in my treatment. I have also been informed of the expected benefits, risks involved, possible consequences, and the possibility of complications associated with my treatment. No warranty or guarantee has been made to me as to the results. I have had the opportunity to ask any questions I have regarding the treatments and home care services I intend to receive. All my questions have been answered in a satisfactory manner. I understand that the explanations I have received are not exhaustive and that other more remote risks and consequences may arise. I also consent to accept the supervision of my care as dictated by federal and state law.

Acknowledgment of Prohibition on Hiring Kaerbear's Workers: I understand and acknowledge that, to the maximum extent permitted by applicable law, I am prohibited from hiring, directly or indirectly, any caregiver or other worker assigned by Kaerbear's to provide any home healthcare and/or personal care services to me during the period that I am receiving such services from Kaerbear's and for the one (1) year period immediately following the last day on which I receive any such services from Kaerbear's. I understand that this prohibition extends to and prohibits me from accepting any home healthcare and/or personal care services from any such caregiver or worker during the time period identified in the preceding sentence. I understand and acknowledge that in the event I engage in any action prohibited by this paragraph, that shall constitute a breach of this Agreement and Kaerbear's will suffer irreparable harm or injury that may be difficult to ascertain at the time of the breach. Therefore, I agree to pay Kaerbear's $10,000.00 for each caregiver or worker I hire and/or accept services from in violation of this Agreement and acknowledge that this amount is a reasonable and fair valuation of Kaerbear's potential losses and actual damages that may result therefrom, acknowledging the difficulty of ascertaining and evaluating all such harm and damages that will be sustained. I agree that this amount does not constitute a penalty and that these damages are in addition to any other relief to which Kaerbear's may be entitled.

Medicare/Medicaid Information: I certify that any information given to me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made to Kaerbear's on my behalf. I understand that to receive Medicare covered home care services, I must meet the criteria as outlined under Medicare Coverage Information contained in the Kaerbear's Patient Handbook.

Permission to Photograph or Video Tape: I hereby authorize Kaerbear's by this written release, to video tape or photograph me during the course of my treatment.

Release of Information: I hereby authorize Kaerbear's by this written release, to view, furnish, obtain, and receive information from my medical record, including photographs or video taken of me, to any insurer, compensation carrier, health care facility, welfare agency, physician, or any health care provided for reasons of financial assistance or continuity of medical care. Regulatory and accrediting agencies also have my permission to review my medical records. Personal Health Information will be kept confidential and will not be disclosed except for legitimate purpose stated in the Federal Privacy Act. Assessment information will be collected for quality and payment purposes.

Financial Agreement: I certify that any information I provide in applying for services under the Title XVIII of the Social Security Act is true and correct. I authorize release of records required to act on request for payment. I request that payment for authorized benefits from Medicare, Medicaid, or other responsible payor be made on my behalf to Kaerbear's.

For non-insurance covered services, or insurance coverage with a designated copayment, I agree to promptly pay Kaerbear's as bills are presented to me, at Kaerbear's prevailing rates. I understand that Kaerbear's is required to adhere to all applicable wage and hour laws related to overtime and I agree to be billed accordingly. Kaerbear's is hereby authorized to a) investigate my credit history and employment status; b) obtain credit information from credit reporting agencies; c) make inquiries as to insurance coverage; and d) make such other inquiries as are reasonable and appropriate under the circumstances. I understand that all past balances shall bear interest at the rate of 1½% per month, or such other maximum rate allowed. Should I fail to make payment in accordance with Kaerbear's terms and it becomes necessary to collect any outstanding balances through the judicial process or otherwise, I agree to pay costs of collection, including reasonable attorney fees. This agreement is binding upon my heirs, executors, administrators, and equal representatives. My liability, if any, for payment is identified below:

Services to be provided and client liability for payment:

__Medicare A __Medicare B __Medicaid __Private Insurance __Self Pay __Medicaid Waiver __other (explain)

Type of service and rate that I am responsible for are:

HHA___ Rate per visit/hr$___ Nurse RN/LPN__ Rate per visit/hr$___ Physical Therapy___ Rate per visit $___

Occupational Therapy_____ Rate per visit $___ Speech Therapy ____ Rate per visit $____ Social Services_____ Rate per visit $___

CoPay _____ **Deductible** _____ **Health Insurance Claim Number**_____ **Other** _____

Frequency and Duration for each Discipline (write discipline/number of visits per week x number of weeks) (ex: RN 3x4):
1. 2. 3. 4. 5. 6.

Assignment of Benefits: I authorize payment directly to Kaerbear's of any and all benefits due to me from insurance policies covering Kaerbear's otherwise payable to me.

Financial Responsibility and Personal Guarantee: I understand that I am fully financially responsible to Kaerbear's for charges not paid by any third party payor, and I personally and individually unconditionally guarantee the full and prompt payment of all monies due under this Agreement when they become due. All payment due must be made by check or money order.

Consultation: I hereby give the agency personnel permission to discuss my care and medical history with: _____
_____.

Assumption of Risk and Release of Liability Relating to COVID-19: I understand and acknowledge that Kaerbear's cannot guarantee that, during the course of treatment and the provision of services, I and any individuals present during the provision of such treatment or services will not be exposed to or contract COVID-19. I also understand and acknowledge that if I choose to receive such services from Kaerbear's, I may be exposing myself to and/or increasing my risk of contracting or spreading COVID-19 and understand that it is my responsibility to take reasonable precautions while receiving such treatment and/or services to avoid exposure to COVID-19, which includes, but is not limited to, wearing a mask. By signing my name where indicated below, I acknowledge that I have read and understand the above warning and have elected to accept the risk of contracting COVID-19 in order to utilize Kaerbear's services, and I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any illness or injury to myself (including, but not limited to, personal injury, disability, and death), damage, loss, claim, liability, or expense of any kind that I may experience or incur in connection with exposure, infection, and/or spread of COVID-19 relating to my receipt of any and all treatment and services from Kaerbear's. I hereby release to the maximum extent permitted by law, covenant not to sue, discharge, and hold harmless Kaerbear's, including its owners, officers, agents, employees, and other representatives, and Kaerbear's subsidiaries, affiliates, related companies, and their owners, officers, agents, employees, and other representatives (hereinafter collectively "Released Parties"), from any and all damages, claims, losses, expenses, costs, judgments or settlements arising from any such claims at all phases of litigation and levels of trial and appeal (including reasonable attorneys' fees and costs), expenses, or liability resulting from or arising out of the exposure, infection, and/or spread of COVID-19 related to any treatment and/or services I receive from Kaerbear's. I understand and agree that this release includes any damages, claims, losses, expenses, costs, judgments or settlements of any kind, expenses, or liability based on the actions, omissions, or negligence of the Released Parties, regardless of whether any COVID-19 infection occurs before, during, or after receiving treatment or other services from Kaerbear's. I agree that any knowledge by any Released Parties of any medical condition of anyone present for the provision of any treatment or services rendered by Kaerbear's does not change the validity of this release.

Acknowledgement of Receipt of Instruction and Materials: I acknowledge that I have been given a copy of Kaerbear's Patient's Handbook. The following materials have been explained verbally and provided to me in written form.

___ Patient Rights and Responsibilities
___ OASIS Privacy Statement
___ Abuse Reporting 800 number
___ Advance Directive Information
___ Agency Emergency Plan (verbal)
___ Complaints Process
__ Notice of Privacy Practices
__ Agency Safety Book
__ I received a copy of this agreement

Advance Directives: I understand that the Federal Self Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may want to express my wishes in a document called an Advance Directive (Living Will/Healthcare Surrogate Designation) so that my wishes may be known when I am unable to speak to myself.

I have a Living Will __Yes __No I have a health care Surrogate Designation __Yes __No
If yes to either question, you must provide a copy to agency for Kaerbear's to honor your request.

Governing Law. This Agreement, and any claims or disputes relating thereto, shall be governed by, and construed and enforced in accordance with, the laws of the State of Florida without giving effect to the conflicts of law principles thereof.

Alternative Dispute Resolution. In the event of any dispute arising out of or relating to this Agreement or the breach of this Agreement, the parties hereto shall use their best efforts to settle such dispute by engaging, in good faith, in mediation in an effort to reach a just and equitable resolution thereof. In the event either party refuses to participate in mediation in good faith or the parties are otherwise unable to reach a resolution of such dispute, upon notice by either party to the other, such dispute shall be resolved and determined by binding arbitration administered by the American Arbitration Association in accordance with the provisions of its Commercial Arbitration Rules.

_____ _____
Patient or Legally Authorized Patient Representative Date

If applicable, Relationship and Reason Patient is unable to sign_____

_____ _____ _____
Witness Signature Witness Name Printed Date

A copy of this document is to be given to the patient and the original is to be retained in the patient's clinical record.