BrightStar Care®
HOME CARE | MEDICAL STAFFING
A Higher Standard

BrightStar Care of West Metro Houston Service Agreement

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WEST METRO HOUSTON

SERVICES TO BE PROVIDED TO CLIENT

X CAREGIVER

BrightStar Care of West Metro Houston Rate Sheet

ITEM		RATE	PER	Or	RATE	PER
Certified Nursing Assistant-5+ hours		$24.00	Hour			
Mileage Charge (if applicable)		IRS Rate	Mile			

Safely Home Program-Comprehensive package including a safe transition home after a hospital stay or medical procedure.

*Reassessment requirements are based upon type of care as well as changes in condition (i.e. post hospitalization)

**Additional hourly charge may be applied if certain duties require RN delegation, such as, but not limited to: blood sugar checks, ostomy care, catheter care, any specialized training requirements.

The client will notify the BrightStar offices of any requested schedule changes no later than 24 hours prior to scheduled shift. If prior notification is not received for any cancellation or reduction in hours, the client may be responsible for payment of the entirety of the initially scheduled shift, up to a max of 4 hours.

*** Traveling companions requires review of each individual case needs.

_____ _____

Signature by Client or Responsible Party **Date**

CONSENT FOR TREATMENT: I consent to treatment from True Grit Business Ventures Inc., a registered Texas company doing business as BrightStar Care of West Metro Houston ("BrightStar"). I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by BrightStar and sign this consent willingly and voluntarily. I understand that this consent is valid from the date of the initial visit by BrightStar personnel and that I may withdraw my consent at any time by notice to BrightStar, and if I do so, the services will not thereafter be provided. I understand that admission to and continuation of services is subject to BrightStar Policies and Procedures. BrightStar will make every effort to provide for the care and comfort of our client during the hours of service. BrightStar cannot guarantee that the client will not be involved in an unforeseen accident and occur injuries. Accidents can happen to clients, even under the care of our staff and BrightStar cannot be held liable in such event. Every person signing this service agreement is jointly and individually responsible to pay the amounts due to BrightStar for the services provided. If Client terminates or changes the services of BrightStar and subsequently decides to again retain or continue the company's services, the same terms and conditions as set forth in this service agreement will apply unless superseded by a new service agreement. I understand rates are subject to change. I hereby acknowledge that I have carefully read this agreement and rate sheet, including the terms and conditions on subsequent pages, before signing below.

Signature :_____ Date:_____

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TERMS AND CONDITIONS

As the client, or an authorized representative, in signing this document I understand and agree to the following:

1. **Payment**: Payment is due 24 hours prior to the start of care. ***Payment for BrightStar services should only be made payable to BrightStar Care of West Metro Houston.***

2. **Additional or Estimated Charges:** I understand that authorized out-of-pocket expenses will be included in my bill. The estimated charges are based on the services originally requested. Billing will be based on actual time worked by caregivers. The amounts billed may differ from the estimated charges as the client's desires and needs change. Mileage for caregivers using their own vehicle will be billed at .54 cents per mile. All mileage submissions will be submitted to client in conjunction with the weekly invoice.

3. **Property Damages:** In consideration for the health treatment being provided by BrightStar, I hereby release BrightStar, its subsidiaries and affiliates from any and all claims, demand, and causes of action involving all damages to my property except that caused solely by the negligence of BrightStar agents or employees acting within the scope of their employment.

4. **Patients' Rights and Responsibilities**: I understand, have received and have reviewed my patients' rights and responsibilities as given to me by a BrightStar representative

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that BrightStar Care of West Metro Houston may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

BrightStar Care of West Metro Houston has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, BrightStar Care of West Metro Houston will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow BrightStar Care of West Metro Houston to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that BrightStar Care of West Metro Houston has taken action relying on this consent.

_____

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

_____

DATE

_____ _____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: BrightStar Care of West Metro Houston at 832-730-1255.

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Payment Information

I understand that I must provide a valid MasterCard/Visa account information or Bank account information and I authorize True Grit Business Ventures Inc. DBA BrightStar Care of West Metro Houston to charge that account from the date services began.

Please circle: MasterCard/ Visa Card Number: _____

3 Digit Code: _____ Expiration Date: _____

Name on Card: _____

Address of Cardholder: _____

City/State/Zip Code: _____

OR

Bank Routing Number: _____

Checking Account Number: _____

Bank Name: _____

Signature of Payer: _____

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HIPAA/DOCUMENT ACKNOWLEDGEMENT AND PHI CONSENT

☐ I acknowledge that I have received BrightStar Care's Health Insurance Portability and Accountability Act (HIPAA) Statement and Privacy Policy.

CONSENT FOR THE COLLECTION OF PERSONAL HEALTH INFORMATION (PHI)

☐ I hereby authorize BrightStar Care to collect my personal health information

I further acknowledge that I have received and or reviewed the following documents with this folder:

- Signed Service Agreement with Rates (copy to be sent to you)
- Client Privacy Policy
- Transportation Waiver

Printed Name: _____

Signed Name: _____

Relationship to Client: _____

Date: _____