Aging Care ADVOCATES
9280 Bay Plaza Blvd, Suite 700, Tampa, FL 33619
Office (813) 246-4120 (727) 286.3220 Fax (813) 246-4194

AGREEMENT FOR SERVICES

Aging Care Advocates, Inc. ("ACA"), agrees to provide Geriatric Care Management Services to _____, ("Client(s)") as follows:

1. _____ (Initials) *On-Going Geriatric Care Management Services* at the rate of $140 per hour in six minute increments (there is 1 hour minimum, monthly, unless in "WILL CALL" status), with an initial deposit of $500.00 payable by check or credit card. **If after hours** (5:01P.M. to 8:59 A.M.), holidays or on the weekends, *Geriatric Care Management Services* will be billed at the rate of $190 per hour billed in 6-minute increments. Geriatric Care Management Services include all time spent by ACA on behalf of the Client. This includes initial care plan, updates to care plans, telephone calls, visits, correspondence, drive time, documentation, re-applications and continuation of eligibility requirements for programs identified, applications or other contact with the Client, family members, friends, and/or providers. The Client is also responsible for costs and out-of-pocket expenses incurred by ACA on their behalf. ACA sends monthly invoices to the Responsible Party payable by either check or credit card (a service charge may apply).

2. _____ (Initials) *Consultation* at the rate of $140 per hour. If after hours (5:01P.M. to 8:59 A.M.), holidays or on the weekends, *Consultations* will be billed at the rate of $190 per hour billed in 6-minute increments. A deposit of $500 is required prior to the time of the consultation. Time spent during the consult meeting, any follow-up work, research or reports requested will be billed against the deposit and any unused portion will be returned. If the Client or Responsible Party would like to hire ACA on-going the $500 deposit will be held until the end of service. All services moving forward will be billed at the hourly rate of $140 per hour (during regular business hours) and $190 per hour (if after hours) and will be billed at the end of each month payable by check or credit card.

3. _____ (Initials) *Comprehensive Assessment and Evaluation* for a fee of $1,800 ($2,500 per couple). This includes: an initial visit to the Client located within a thirty mile radius of the ACA office, assessment and evaluation of the Client's mental, physical, financial needs, development of a written report that provides recommendations with regards to the Client's specific care needs, and initial referral to programs and/or providers identified by ACA and selected by the Client and/or Responsible Party. Payment is required prior to the assessment meeting by means of check or credit card (a service charge may apply). If further Geriatric Care Management Services are desired following the completion of the assessment process, then a new Agreement for Services will need to be executed by the Client and/or Responsible Party unless indicated at the time of this original agreement by initialing service option #1 above (On-Going Geriatric Care Management Services).

While ACA strives to refer to only providers of high quality services, it makes no representation of, and does not warrant or guarantee the credentials, professional qualifications, experience, services, and/or advise of any third party. The Client is responsible for investigating and evaluating programs, providers, and is solely responsible for their charges. The Client agrees to indemnify ACA for any liability or costs arising out of third party claims, and for any costs of collections incurred by ACA, including reasonable attorney's fees. Any person signing this agreement as a "Responsible Party" is bound by its terms, and is jointly and severely liable with the Client(s) to ACA.

Invoices that are not paid within thirty days are subject to a late fee of 1 ½ percent per month, and may result in cessation of all Geriatric Care Management Services pending satisfactory financial arrangements. Client hereby agrees to pay the default charge together with reasonable attorney's fees for cost of collection and hereby consents to ACA charging the Client's credit card for any past due balance. ACA shall not disclose Client's credit card information (appearing below) to any third party without Client's prior written consent.

This agreement cannot be modified without the written consent of ACA. It may be terminated by any party, with or without cause, upon thirty (30) days written notice. This agreement is prepared in the State of Florida and will be governed by the laws of Florida.

_____ _____

Responsible Party Signature Date

_____ _____

Print Name Relation to Client

_____ _____

Responsible Party's Address Phone Number

_____ _____

Responsible Party's City, State and Zip Code Email Address

Credit Card Information:

Name of Credit Card Holder (Printed): _____

Signature of Card Holder: _____

Type _____ Number _____ Exp. _____ Code _____

Card Holder's Billing Address: _____

Card Holder's City, State and Zip Code: _____

How would you prefer to receive your bill? _____E-mail or _____Regular Mail (please check one)

Would you like to send your bill by e-mail/mail to someone else? (If yes, please enter address below) ___ Yes ___ No

E-mail Address _____ or

Mailing Address_____

City, St., Zip_____