INNER BANKS
HEALTH SERVICES INC

112 Currituck Commercial
Dr, Moyock, NC 27958
(757) 600-8695

OPTION PLUS
CLIENT SERVICE CONTRACT

Person to receive services:

Name:
Address:
City:
State:
Zip:
DOB:

Financial Guarantor:

Name:
Address:
City:
State:
Zip:

(Initial) I authorize charge to credit/debit card on file along with the 3% processing fee for each billing.

(Initial) I authorize a direct debit to my checking account on file for each billing.

(REQUIRED): I am providing valid credit/debit card or banking account information and I authorize INNER BANKS HEALTH SERVICES INC. to charge that account the date of invoice for the total amount of the invoice.

Credit/Debit Card#: **Expiration Date:**

Checking Account#:

Checking Account Routing#:

REQUIRED (SIGNATURE OF GUARANTOR):

Client Name:

Client/POA Signature:

OPTION PLUS
CLIENT SERVICE CONTRACT

Services to be provided:
(3 services must be selected or a service charge will be applied for each missing service under 3)

- [ ] 1. Bathing ($40)
- [ ] 2. Incontinence Care ($25)
- [ ] 3. Quick Clean ($22) 30 minute increments
- [ ] 4. Meal Prep ($20)
- [ ] 5. Transferring ($18)
- [ ] 6. Dressing ($18)
- [ ] 7. Medication Reminders ($10)
- [ ] 8. Service Charge ($10)

Service Schedule:

Care Time Windows:

Every person signing this contract is jointly and individually responsible to pay the amounts due to INNER BANKS HEALTH SERVICES INC. for the services provided. If the client terminates or changes INNER BANKS HEALTH SERVICES INC. services 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continue the company's services, the same terms and conditions as set forth in this service agreement will apply unless superseded by a new service agreement.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 hereby acknowledge that I have carefully read this entire agreement and rate sheet, including the terms and conditions on the reverse side, before signing below. The contract is in effect until terminated by the client or INNER BANKS HEALTH SERVICES INC. (See Discontinuing Services). I hereby consent and authorize INNER BANKS HEALTH SERVICES INC., its agents, and associates to provide care and treatment to me in my home. This contract will be enforced until one (1) year after its signing, except if terminated by INNER BANKS HEALTH SERVICES INC. or the client.

Client Name:

Client/POA Signature:

General: INNER BANKS HEALTH SERVICES INC. is a licensed Home Services Agency and fully compliant with all licensing and NC statutory requirements and compliant with the Health Care Worker Background Check Act. INNER BANKS HEALTH SERVICES INC. conducts criminal background checks on all employees.

INNER BANKS HEALTH SERVICES INC. is an employer of in-home services staff that provide in-home services to clients. INNER BANKS HEALTH SERVICES INC. agrees to furnish services to the client as requested and as mutually agreed between the parties. This contract may be modified, amended, or terminated upon seven (7) days notice by either party (if such notice is given by INNER BANKS HEALTH SERVICES INC., it must be in writing, and if such notice is given by the client, it is the responsibility of INNER BANKS HEALTH SERVICES INC. to note it in the client's record); the reason for termination/discharge will be included in the notice. In the absence of an agreement (refers to modifying the agreement, not absence of agreement) as to the modification or amendment, the client has the right to immediately terminate; however, INNER BANKS HEALTH SERVICES INC. must give a 7-day grace period to the client to find another provider. All INNER BANKS HEALTH SERVICES INC. employees are informed about the company's Policies and Procedures including HIPAA and trained to follow them.

Minimum Hours: INNER BANKS HEALTH SERVICES INC. requires a minimum hourly client commitment of four (4) hours per visit.

Clients signing "Option Plus Client Service Contracts" are not held to a minimum number of hours for Option Plus service.

Wages: The Agency is responsible to pay all wages directly to the in-home worker.

Taxes and Insurance: The Agency is liable for all taxes, unemployment insurance, workers compensation and social security taxes for in-home workers.

Assignment of Duties: The Agency Manager is responsible for assigning duties to the in-home workers and providing their day-to-day supervision.

If a client or family member has a problem with job performance of a direct care worker, he or she will contact INNER BANKS HEALTH SERVICES INC. within twenty-four (24) hours to notify the Agency Manager by calling (757) 600-8695.

In accordance with the INNER BANKS HEALTH SERVICES INC. Policies and Procedures, hiring, firing, and disciplinary action are the responsibility of INNER BANKS HEALTH SERVICES INC. management staff. An agency manager is available during business hours at (757) 600-8695. During non-business hours, trained professionals will be available for any questions, concerns, or complaints at the same number. The agency manager for INNER BANKS HEALTH SERVICES INC. will be responsible for following up on all complaints. A report of appropriate actions will be sent to the client by mail or e-mail.

Client Name:

Client/POA Signature:

Rates/Billing: Fees are based on established rates. Should rates change during the term of this Agreement, INNER BANKS HEALTH SERVICES INC. will provide written notice at least thirty (30) days in advance of the effective date of the change.

Client/Guarantor agrees to pay the charges for the services rendered by INNER BANKS HEALTH SERVICES INC. as and when billed, along with any applicable late charges and other fees and expenses. Invoices for services and expenses will be sent to the Client or Guarantor/Responsible Party on a regular basis and are due upon receipt. Any invoices not paid within seven (7) days of the invoice date will be subject to late charges of one and a half percent (1.5%) per month, or eighteen percent (18%) per year.

Any additional Responsible Party shall also be fully responsible for any fees, charges or expenses that arise from the terms of this Agreement as if they were the direct recipient of services. Partial payment will be applied first to the oldest late charges, then to the oldest unpaid bill, until all invoices are paid in full and then to any other charge.

Should it be necessary to obtain the services of an attorney to collect unpaid amount due to INNER BANKS HEALTH SERVICES INC., the Client agrees to be fully responsible for payment of any all attorney fees.

INNER BANKS HEALTH SERVICES INC. uses its best efforts to keep careful records and to bill accurately. Should the Client believe that any billing received from INNER BANKS HEALTH SERVICES INC. is incorrect, theclientt should write or call immediately and identify any item in dispute. The sooner INNER BANKS HEALTH SERVICES INC. is notified, the sooner the problem can be investigated. INNER BANKS HEALTH SERVICES INC. will assume that any bill that is not questioned by the client within seventy-two (72) hours of the invoice date is accurate and payable in full. Equipment and material for workers used in providing services is a client's responsibility.

A delayed payment by an insurance company or public agency is not a valid reason for late payment for services. INNER BANKS HEALTH SERVICES INC. does not file claims with insurance companies on behalf of clients, nor does INNER BANKS HEALTH SERVICES INC. negotiate disputed claims. However, if the client provides the necessary information in advance, INNER BANKS HEALTH SERVICES INC. will use their best efforts to conform to the billing requirements of the client's insurance company.

Client Name:

Client/POA Signature:

Indirect/Direct Hiring: The client will not hire, on an indirect or direct basis, any caregiver who is an employee of INNER BANKS HEALTH SERVICES INC. The client agrees to not hire on an indirect or direct basis any previous INNER BANKS HEALTH SERVICES INC. employee from at least 1 year of their last employment date with INNER BANKS HEALTH SERVICES INC. In the event that the client violates this condition, the client/guarantor/responsible party agrees to pay INNER BANKS HEALTH SERVICES INC. a placement fee of one hundred percent (100%) of the Caregiver's average monthly wages or a placement fee of ten-thousand dollars ($10,000.00), whichever is greater.

Sharing contact information: The client agrees to withhold sharing contact information (emergency contact information) with INNER BANKS HEALTH SERVICES INC.'s employees. The client agrees to not contact INNER BANKS HEALTH SERVICES INC.'s employees unless in the event of an emergency. All communication with INNER BANKS HEALTH SERVICES INC. should be done via the office manager via phone call, text message, email, written, or verbal. Scheduling done through the caregiver and not through INNER BANKS HEALTH SERVICES INC.'s management constitutes a breach of contract.

Discontinuing Services: INNER BANKS HEALTH SERVICES INC. has the right to terminate this agreement upon seven (7) days notice required with the reason for termination/discharge stated (it is not applicable if the worker's safety is at risk and documented), including if the client violates its terms and conditions, including failure to pay invoices on time. The Client may terminate this Agreement at the Client's discretion by notifying INNER BANKS HEALTH SERVICES INC. via written statement (including text message). If services are ordered by phone or otherwise supplied prior to the date of this Agreement, the terms of this Agreement shall apply to all services rendered, including any services rendered prior to the execution of this Agreement.

Breaching contract: In the event that the client at any point breaches their client service contract with INNER BANKS HEALTH SERVICES INC., the client agrees to pay INNER BANKS HEALTH SERVICES INC. one (1) month's worth of the client's average monthly charge.

Scheduling/Substitutions: INNER BANKS HEALTH SERVICES INC. understands the personal nature of the services provided by each caregiver. With reasonable notice, the client (or other responsible party) has the right to request replacement of a specific caregiver and to request such additional assistance as is agreed to be necessary. INNER BANKS HEALTH SERVICES INC. reserves the right to substitute employees at its discretion and to make supervisory visits. Every effort will be made to provide a caregiver; however, INNER BANKS HEALTH SERVICES INC. cannot guarantee scheduling. INNER BANKS HEALTH SERVICES INC. strives for continuity of care but suggests that a family member or friend be designated as a backup caregiver for those rare instances when INNER BANKS HEALTH SERVICES INC. may be unable to provide service.

Client Name:

Client/POA Signature:

Emergency Medical Treatment: Client authorizes INNER BANKS HEALTH SERVICES INC. to seek emergency medical treatment for client in the event of a medical emergency that may endanger client's life or cause disfigurement or significant discomfort if delayed. The client's relative or responsible party will be notified in case of an emergency.

Insurance/Liability: Client(s) agree(s) to carry a standard homeowner's insurance policy or similar tenant's policy on the client residence. Not carrying a standard homeowner's insurance policy or similar tenant's policy on the client residence constitutes a breach of contract. INNER BANKS HEALTH SERVICES INC. limits its liability for property loss or damage to claims filed within 30 days of occurrence. All losses require a police report. However, to prevent any potential losses, the client agrees to remove all items of concern prior to services starting. Money or gifts may not be given directly to any INNER BANKS HEALTH SERVICES INC. employee. Gifting money or gifts directly to any INNER BANKS HEALTH SERVICES INC. employee constitutes a breach of contract. Client agrees to hold INNER BANKS HEALTH SERVICES INC. harmless from liability for any damage of any nature caused by the use of any automobile while performing services for the client. INNER BANKS HEALTH SERVICES INC. will make every effort to provide for the care and comfort of the client during the hours of service. INNER BANKS HEALTH SERVICES INC. cannot guarantee that the client will not be involved in an unforeseen accident and incur injuries. Accidents can happen to clients even under the care of our staff, and INNER BANKS HEALTH SERVICES INC. cannot be held liable in such an event.

Client Name:

Client/POA Signature:

Confidentiality: All client information is kept confidential. INNER BANKS HEALTH SERVICES INC. may discuss the client(s)' health information with the client(s) healthcare providers as appropriate, and the client agrees to allow the accrediting agency to review the contents of the client's record. The client also permits INNER BANKS HEALTH SERVICES INC., in the case of an emergency, to provide information as deemed necessary to the emergency contact listed in the client's chart. The client also permits INNER BANKS HEALTH SERVICES INC., in the event of non-payment, to provide client information to collection agencies in order to recoup payment.

Identifying and reporting abuse/neglect: Clients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation. When abuse or neglect is suspected or identified, the employee/client is to report observations or findings immediately by phone or otherwise to Agency Manager **Joshua Kannon, (757) 600-8695, 112 Currituck Commercial Dr, Moyock, NC 27958** (or in writing at the address above). The Agency Manager will review the information presented and investigate if this is a reportable incident. If so, the information will then be reported to the appropriate county social service agency. Failure to report is misdemeanor and exposes the non-reporter to potential civil damages. Abuse, Neglect or Exploitation may be reported to the state's 24 hour toll free hotline at **1-800-624-3004**.

Compliant/ Grievance Process: When a client is admitted to the Agency, he/she is to be given an admission packet that includes a copy of the Agency Bill of Client Rights and Responsibilities. This policy indicates that grievances are to be filed with the Agency Manager. The fact that the policy was given to the client is to be recorded in the clinical record.

Client Name:

Client/POA Signature:

All grievances and concerns are to be dealt with by the agency manager or his/her designee. All grievances received are to be documented in the client's record by the agency manager or designee within 72 hours of receiving the complaint. It is also to be noted in a log kept by the agency manager. The resolution of the problem is also to be documented in the same manner. Any grievance received after hours, on weekends and holidays, and whenever the office is closed is handled on the next business day. Each written or verbal grievance received is to be responded to in writing by the agency manager within ten (10) days. This information is reviewed by the agency manager, and a complaint form is completed by the agency manager. Each person involved is interviewed by the agency manager, who then evaluates all collected information. After thorough evaluation, the agency manager makes a determination and formulates a decision, notifying all persons involved.

All information regarding activities, investigation, analysis, resolution and outcomes are documented in the Agency Manager's log and in the client's chart within 30 days of the complaint. The response is to explain the decision rendered by the Agency and it is to notify the client of his/her right to appeal. A copy of the outcome is to be filed in the clinical record and noted in the Agency Manager's log.

If the client files an appeal, it is to be reviewed and responded to by a member of the Governing Body within thirty (30) days of its receipt by the Agency. The response to the appeal is to be filed in the client's record and noted in the Agency Manager's log.

Clients are advised that they may lodge complaints with the state by calling the 24-hour toll-free number (within NC): 1-800-624-3004, Local: 919-855-4500 or writing to:

FAX: 1-919-715-7724, EMAIL: Complaint Intake: dhsr.concern@dhhs.nc.gov

OR

Complaint Intake Unit

North Carolina Division of
Health Service Regulation

2711 Mail Service Center

Raleigh, NC 27699-2711

Client Name:

Client/POA Signature: