

PATIENT/CLIENT NAME: _____ DATE: _____

Deposits

I agree to pay simultaneously with the signing of this Agreement \$ _____, in the form of a check number _____ / cash/and/or other agreed upon terms, a one-week deposit for services to be rendered. This deposit will be applied to your last invoice of service. The Driver's License number of the depositor is _____ in the State of _____.

Overtime/Holidays

All charges for services rendered on holidays or rendered by the same individual, at my request in excess of forty (40) hours during any work week will be one and one-half times the applicable rate. Holidays applicable for overtime rates are: New Year's Eve, New Year's Day, Easter, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, Christmas Eve, Christmas Day, and other local holidays as indicated:

Additional Terms:

Hiring of Matrix Home Care employees

I acknowledge the considerable expense incurred by Matrix Home Care in advertising, recruiting, evaluating and retaining employees. Accordingly, I agree that during the term of this Agreement and for one (1) year after termination of this Agreement, I will not (without prior written consent of Matrix Home Care) solicit, employ, or seek to employ any individual who is currently employed by or has been an employee of Matrix Home Care within the last year. Nor will I induce any such person to leave his or her employment with Matrix. If I violate the foregoing provisions, I agree to pay Matrix Home Care a finder's fee of Ten Thousand Dollars (\$10,000) for each such employee.

I agree not to pay the employees directly. Employees are not authorized to accept, have custody or the use of cash, credit cards or other valuables of a client. If cash or other items are advanced to employee, I waive any right to offset this amount from the invoice. Matrix Home Care will not be responsible for claims against its Fidelity Bond unless such claims are reported in writing to Matrix and to the local police within ten (10) days after notice of loss.

I understand that live-in employees residing on my premises are scheduled for ten (10) hours of duty of "on call" time per day, and their pay is based on this schedule. If client needs to change shifts or working hours to keep an employee on duty for more than ten (10) hours per day, authorization from Matrix Home Care must first be obtained and wage and billing adjustments will be made.

Service

I agree to pay Matrix Home Care a minimum of four (4) hours of service charges on behalf of any employee who reports for duty should I decide to terminate this Agreement without proper notice.

Service Interruption

I understand Matrix Home Care uses its best efforts to provide uninterrupted services; however, sometimes interruptions are unavoidable. During any interruption of service, I understand that I may be responsible for and agree to provide or arrange for backup care. However, Matrix Home Care will make all reasonable attempts to provide service through their caregivers or another agency.

Termination

I understand that I may terminate this Agreement by giving at least four (4) hours notice to Matrix Home Care. I understand that Matrix Home Care may terminate this Agreement by providing at least three (3) days notice or other minimum notice required under applicable state law. I recognize that notification may be furnished verbally in person or by telephone and that written confirmation will follow by mail. In those circumstances in which the life, safety, or well-being of agency personnel is or may be jeopardized, Matrix Home Care may terminate this Agreement without prior notice.

Freedom of Choice

I understand that I have the right to choose any provider of personal care services. I voluntarily select Matrix Home Care as my provider of services.

Note: This form must be signed by the Matrix Home Care patient/client unless the patient/client is a minor, incompetent, or physically incapable of signing.

I have read and fully understand the content of the two-page Consent Form and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I," "me" and "my" refer to and include, in addition to the undersigned, that patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Matrix Home Care to provide service to the patient/client.

**Patient's/
Client's
signature**

PATIENT/CLIENT SIGNATURE

AUTHORIZED REPRESENTATIVE IF
PATIENT/CLIENT CANNOT SIGN

WITNESS SIGNATURE

PRINT NAME OF AUTHORIZED REPRESENTATIVE

DATE

AUTHORIZED REPRESENTATIVE'S
RELATIONSHIP TO PATIENT/CLIENT