Broward Lifecare, LLC
DBA - BrightStar Fort Lauderdale / Pompano Beach Service Agreement and Consent

Person to Receive Services:

Client Name: ______________________ Date of Birth: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: ______________________

Phone: ______________________ Alternate Phone: ______________________ Email ______________________

Consent for Treatment: I consent to treatment from BrightStar Fort Lauderdale / Pompano Beach consistent with an established plan of care. 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 incur 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 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continue the company's services, the same terms and conditions as set forth in this service agreement will apply unless superseded by a new service agreement.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 entire agreement and rate sheet, including the terms and conditions on the reverse side, before signing below.

Patient's Rights and Responsibilities: I understand, have received and reviewed my patient rights and responsibilities as given to me by a BrightStar Representative.

Client's Handbook: I have received the Client Handbook from the agency and it has been verbally explained to me by a BrightStar Representative. All my questions and concerns have been addressed to my satisfaction.

Release of Personal Information: I consent and request that copies, if necessary, of my prior medical records be delivered to BrightStar to establish or continue my home care plan. I also authorize BrightStar to release copies of my medical records or reports of such portions or summaries as it may be relevant, to other healthcare providers and regulatory or accrediting bodies for the purpose of continuing and coordinating my home care plan and for quality assurance, survey and accreditation purposes.

Advance Directives: I have received and reviewed Advance Directives information specific to the state. I certify that I have read and received a copy of the Patient Rights and Advance Directives information specific to my state of residence and that I am the patient, or am acting in the patient's behalf, and accept their terms. I give my permission for BrightStar to speak to all identified members of my patient care team.

☐ I have not prepared an Advance Directive regarding my health care
☐ I do not wish to make an advance directive at this time
☐ I have prepared an Advance Directive regarding my healthcare *If yes, copy*: ☐ Requested ☐ Received

Types: ☐ Living Will ☐ Healthcare Surrogate Designation ☐ Anatomical Donation

Name of Healthcare Surrogate: ______________________ Phone Number: ______________________

Consent to Photograph: I hereby consent for BrightStar to take photographs for the purpose of documenting my progress and medical condition. These photographs will become part of my medical record and may be forwarded to my Physician and/or Insurance Company.

Consent for Assistance with Medications: I have been informed by BrightStar that I may be receiving assistance with self administration of medication from an unlicensed person (excluding narcotics).

Consent for Supervision of Employees: I authorize BrightStar to provide supervision of all non-skilled employees involved in my plan of care.

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Client/ Responsible Party/ Legal Guardian – Signature   Print Name   Date

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BrightStar Representative/ Witness – Signature   Print Name   Date