FOOT CARE NURSING SERVICE AGREEMENT
Private Pay to Patients

THIS AGREEMENT made and entered into this_____(date), by _____and (hereinafter referred to as "Provider"), and, _____ (herein after referred to as "Center").

W I T N E S S E T H:

WHEREAS, Center is in the business of operating and managing one or more nursing centers, and,

WHEREAS, Provider is in the business of providing practice management services to foot care professionals, and,

WHEREAS, Solely as a convenience to and benefit for its residents, and Center desires to engage Provider to make available foot care services for those residents in need of and desiring the same upon the terms and conditions hereinafter set forth, and

WHEREAS, Provider is willing to make available such services at the locations hereinafter listed upon the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual covenants and conditions

1. **Services Provided.** Provider hereby agrees to arrange for the availability of Provider foot care services for those residents who are in need of and elect to utilize such services.

2. **Obligations of Provider.** Provider hereby agrees, at its own expense, to provide to Center all reasonably necessary administrative assistance required to provide the foot care services referenced hereunder. Such services shall be made available on a periodic basis as scheduled separately by Provider and Center.

a. The Provider shall purchase and shall keep in full force and effect throughout the term of this agreement professional liability insurance providing coverage at least one million dollars per occurrence.

b. Provider shall provide all required office supplies for foot care services provided hereunder.

c. Under no circumstances will Center be financially responsible to Provider or any services rendered hereunder to one of its residents.

3. **Obligations of Center**

a. Center shall cooperate with Provider's efforts in providing available space to serve its residents.

b. Center shall cooperate with Provider’s efforts in billing professional services rendered to patients by furnishing demographic data and and assisting in obtaining informed consent for treatment and assignment of benefits by the resident or other responsible party for all encounters.

4. **Collections.** In the event that Center shall directly receive any payment for professional services rendered to its residents, said payment shall be endorsed or paid to practitioners and delivered to Provider for administration hereunder.

5. **Scheduling.** Center and Provider shall mutually agree upon the scheduling of such residents utilizing foot care services hereunder.

6. **Binding Effect.** This agreement shall be binding upon, and insure to the benefit of, Provider, its successors and assigns, Center, its successors and assigns.

7. **Voluntary Termination.** Either Center or Provider may terminate this agreement for any reason upon thirty (30) days prior written notice to the other party.

IN WITNESS WHEREOF, the parties here unto have executed this Agreement on the date first above written.

_____ _____

Provider Authorized Signature for the Center.

CONSENT FOR FOOT CARE NURSING TREATMENT
Private Pay to Patients

Permission is hereby granted to _____(facility name) to facilitate the provision of foot care services and procedures as may be deemed necessary by the attending physician or other physician. I understand that this will include foot care examinations, review of medical records, and provision of services including toenail and callus care, patient education, and appropriate referrals for other indicated treatment.

I understand that the Foot Care Provider is not an employee of _____(facility name) and that the Provider is an independent, licensed Nurse, exercising his/her independent professional judgments concerning foot care and treatment of the resident listed below.

I understand that these services will not be billed to Medicare or other insurance providers. I agree to pay the Provider the amount of $_____ for each care visit made and documented.

I will notify the staff at _____ (facility name), if I want foot care service to stop for the resident listed below.

_____
Resident

_____
Responsible Party
(Please make sure to note above who you talked to if this is a verbal consent.)

_____
Witness
(The person who called to get verbal consent.)

_____
Date

Template for Responsible Party Notification of podiatry service for resident.

Private Pay to Patients

Date:_____
Name: _____
_____
_____

Dear

(Your Facilities Name) is pleased to announce plans to add a Foot Care Nurse to our extended staff of caregivers. The Nurse will come into our facility on a regular basis to provide comprehensive foot care for our residents (**THIS SERVICE MAY BE COVERED BY MEDICARE, MEDICAID AND ALL OTHER INSURANCES IF PERFORMED BY A PHYSICIAN BUT WILL NOT BE BILLABLE WHEN PROVIDED BY A SPECIALIST NURSE**). This service has, at times, been a problem in that the residents are unable to visit the doctor's office due to transportation or health problems. Ambulance transportation is costly for the family, and car travel is not an option for many residents. This service will be billed to you at the rate of $_____ per visit, payable directly to the Nurse.

The Podiatrist will provide the following service:

- ♥ Routine foot care (trimming nails every 63 days for those who receive care.)
- ♥ Diabetic foot care
- ♥ Trimming of mycotic, ingrown or incurvated nails (Onychomycosis)
- ♥ Treatment of painful callouses and corns

We at (Your Facility Name) are pleased that we have found a Foot Care Nurse who will provide foot care for our residents in our facility, on an on-going basis with frequent follow up. We will need your approval for the Nurse to see your loved one. Thank you for helping us meet the goal of better meeting the health care needs of our residents.

Your suggestions and comments are invited, and if you would prefer your loved one not be included in this program, please contact us at (Your Facility #) and let us know what alternative provisions you would like to make so that your loved ones foot care needs may be met. Please indicate, on the **permission form (included in this envelope)**, whether you want your family member to participate in this program and return this form to (Your Facility Name) within 10 days of receiving this notice. **You may also call us** to give approval over the phone.

Thank you so much, for allowing (Your Facility Name) to improve our comprehensive health care program for your loved one.

Sincerely,
Your Name