



# Florida's Choice HEALTH CARE

## Cost for Services

**Florida's Choice Health Care** Geriatric Care Managers can not only SAVE family's money...but save valuable time, loss pay from work, aggravation, stress, anxiety, frustration and much more... FOR EXAMPLE:

*The average costs of coordinating care for a loved one from out-of-town can be substantial!  
Below are the estimated costs an individual might expect to spend in just ONE week:*

- Week Off From Work \$1500.00
- Round Trip Flight: \$500.00
- Car Rental: \$35.00 x 7 \$245.00
- Hotel: \$150.00 x 7 \$1050.00
- Food: \$75.00 x 7 \$525.00
- Miscellaneous: \$500.00

**Average Cost of travel "Before" Coordinating Care is \$4320.00 per week**

**Florida's Choice Health Care's** AVERAGE ASSESSMENT'S are between (1) one and (5) five hours and can range from about \$250-\$1000 depending on the time involved, the complexity of the case and whether a written report or formal legal document is necessary. Flat rates may also be negotiated depending on the situation and complexity. In many instances, Florida's Choice Health Care managers, using their experiences and resources, can step in to support the family at a critical time in their search for the best care for their loved one.

**Florida's Choice Health Care** charge clients in a variety of ways, but typically our hourly rates are between \$100-\$150 / hr.

### **RATES "AFTER" INITIAL ASSESSMENTS**

- Mon-Friday: 9am – 5pm \$100.00 per hour
- Mon-Friday: 5pm – 9am \$150.00 per hour
- Weekends: \$200.00 per hour

*Medicare, Medicaid and health insurance very rarely pay for these costs, long term care insurance might, but most often this is an out-of-pocket cost. In addition to the convenience and security Florida's Choice Health Care provides, our Care Managers usually save families money despite being an out-of-pocket cost because their needs assessments align an individual's present condition with only those services that are necessary at that point in time. This prevents unnecessary fees from home care providers and assisted living residences.*

**Continue... to see what options best fit our family's needs!**

**Florida's Choice Health Care Management Agreement Form**

**Client Name/ POA** \_\_\_\_\_ / \_\_\_\_\_ **agrees to choose Florida's Choice Health Care** to provide geriatric care management services to: \_\_\_\_\_ / \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**MEDICARE:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
("Client(s)") as follows:

**Free Initial Consultation (Usually 30 min)**

(Option #1)

Advisory Assessment

*Primarily used for short term care short term solutions*

\_\_\_\_\_ (Initials) (2-3 hour) Advisory Assessment and Evaluation for a fee of \$600.00 per person (\$750.00 per couple). This includes an initial visit to the Client located within a (20) twenty mile radius of the St. Petersburg office, meeting with immediate care giver, assessment and evaluation of the Client's immediate options, physical, and financial needs, verbal recommendations with regards to the Client's short term care needs, and initial referral to programs and/or providers identified by Florida's Choice Health Care and chosen/selected by the Client and/or responsible party.

(Option #2)

Comprehensive Assessment

*Primarily used for more complex and long- term solutions*

\_\_\_\_\_ (Initials) (5-8 hour) Comprehensive Assessment and Evaluation for a fee of \$1000.00 per person (\$1300.00 per couple). This includes an initial visit to the Client located within a (50) fifty mile radius of the St. Petersburg office, meetings with care team which may include, physicians, case managers, social workers, facility administrators, assessment and evaluation of the Client's mental, physical and 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 Florida's Choice Health Care and chosen/selected by the Client and/or responsible party.

RATES "AFTER" INITIAL ASSESSMENTS

- Mon-Friday: 9am – 5pm \$100.00 per hour
- Mon-Friday: 5pm – 9am \$150.00 per hour
- Weekends: \$200.00 per hour

Liability Disclaimer

*While Florida's Choice Health Care 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 Florida's Choice Health Care for any liability or costs arising out of third party claims, and for any costs of collections incurred by Florida's Choice Health Care, including reasonable attorney's fees. Any person signing this agreement as a "responsible party" will be bound by its terms, and is jointly and severly liable with Client to Florida's Choice Health Care.*

Florida's Choice Health Care LLC. 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 Florida's Choice Health Care. It may be terminated by any party, with or without cause, upon thirty (30) days written notice. This agreement is made in the State of Florida, will be governed by the laws of Florida, and venue of any action to enforce it will be in Pinellas, Florida.

\_\_\_\_\_  
Responsible Party Signature Date

\_\_\_\_\_  
Print Name Relation to Client Date

\_\_\_\_\_  
Responsible Party's Address

\_\_\_\_\_  
Responsible Party's Phone Number 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

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 \_\_\_\_\_

*Invoices that are not paid within thirty days are subject to a late fee of 10 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 Florida's Choice health Care LLC. charging the Client's credit card for any past due balance.*

*This agreement cannot be modified without the written consent of Florida's Choice Health Care. It may be terminated by any party, with or without cause, upon thirty (30) days written notice. This agreement is made in the State of Florida, will be governed by the laws of Florida, and venue of any action to enforce it will be in Hillsborough County, Florida.*