CONTRACTOR INVOICE

Phone: 561-998-3211
Fax: 561-998-3250

CONTRACTORS NAME

_____

Client: _____
Address: _____
_____

Month/Year:	Sat	Sun	Mon	Tues	Wed	Thurs	Fri
Date:							
PERSONAL CARE Bath							
Oral Hygiene							
Hair Care							
Assist Dressing							
Shave							
Skin Care							
Toileting							
NUTRITION Prepare Breakfast							
Prepare Lunch							
Prepare Dinner							
Prepare Snack							
Assist Eating							
Grocery Shopping							
ACTIVITIES Ambulation							
Transfer: Bed/Chair							
Turn/Reposition							
ROM Exercises							
RECORD TPR							
Assist with Meds							
Food Intake							
Fluid Intake							
Urinary Output							
Bowel Movements							
HOMEMAKING Linen Change							
Laundry							
Wash Dishes							
Light Housework							
ELIMINATION Bowel Movement							
Incontinence							
Urination							
Catheter Care							
Ostomy Care							

WEEK OF _____

Report All Times to the Nearest ¼ Hour					
Day	Date	Time Started	Time Finished	Daily Total	Client Initials
SAT					
SUN					
MON					
TUES					
WED					
THURS					
FRI					
Total Hours for Week to Nearest ¼ Hour →					

Type of Service Rendered: _____

CONTRACTOR: My signature indicates accurate time worked by me. I understand this Client Care Record must be signed by me and the client or his/her representative for me to be paid for this job.

CLIENT: My signature indicates that the contractor's work was performed satisfactorily and the times indicated above are accurate. I agree to pay for the services immediately upon receipt of invoice. Should collection procedures be necessary, I agree to pay all costs, including reasonable attorney's fees. I further agree not to employ this Home Health Aide privately for a period of two (2) years from this date. If I violate this agreement, I will pay Platinum Select Nursing LLC, upon demand, $20,000 in liquidated damages. I acknowledge and agree that the payment required by this liquidated damages clause is a reasonable forecast of the damages likely to result from my breach of this agreement and is not a penalty of any kind.

Client Signature _____

Contractor Signature _____

License # if applicable _____

Comments: _____
_____
_____
_____
_____

A completed copy of this Client Care Record is due to the office each SUNDAY by 5pm the latest.