One Stop Health Shop LLC (OSHS) is a care coordination company that focuses on the transitional aspect of care coordination. Assisting with coordination of care, to limit the chances of (re)admission into a healthcare facility.

This is not a contract and can be canceled at any time.

Hours of operation: Mon-Fri from 9am-4:30pm.

Mission Statement: Provide every client with necessary tools and assistance needed to navigate through the healthcare system to fit their individual healthcare needs.

Care Coordinators are vital healthcare associates that coordinate communication between clients, family members, medical professionals, administrative staff, and insurance companies to ensure that clients are receiving the best possible healthcare services

Privacy Statement

Coordination of Care: Client hereby permits the use or disclosure of Client's health information to coordinate or facilitate Client's continued treatment and care for case management purposes. This may include, but is not limited to health care professionals. We are committed to maintaining client's confidentiality. We will only release healthcare information about clients in accordance with federal and state laws and ethics of the advocacy profession.The use and disclosure of protected health information is for the purpose of scheduling health care services as per State and federal guidelines, and is consistent with those laws and guidelines.

Healthcare Operations: Client hereby permits disclosure for purposes of payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Client's behalf for payment related questions.

Disclosures of client's information which do not require client consent: instances where we may be required to use and disclose information without client's consent. This includes, but is not limited to,: Information client and/or client's Family report about physical or sexual abuse; then by Florida State Law we are required report this to the Department of Children and Family Services; Information to remind client . Abiding by title IV of the Civil Right Acts of 1964. No person shall be denied services because of race, sex, color, creed, handicap or age.

Client Name: _____ DOB:_____

Home Address_____CITY:_____ ST:____ ZIP_____

Phone: _____ Email: _____

Current Location:_____

Address_____CITY:_____ ST:____ ZIP_____

Phone: _____ Email: _____Fax_____

ALLERGIES:_____

Height: _____ Weight: _____ Sex: ____ Social Security Number:

Healthcare provider::_____

Address_____CITY:_____ ST:____ ZIP_____

Phone: _____ Email: _____Fax_____

Emergency Contact Info:

Name: _____ Relationship: _____

Phone: _____ Email: _____

(2) Name: _____Relationship: _____

Home Phone: _____ Email: _____

Roles & Responsibility:

DO's:

- Increase communication amongst medical providers and clients.
- Schedule medical appointments along with transportation, and caregivers if needed.
- Provide weekly over the phone wellness check to ensure the client is following all recommendations.
- In person wellness check to ensure that the client's environment is conducive to meeting all of the care plan goals.
- Monthly care plans to ensure all goals are met.
- Communicate with clients via telephone, email, or mail regarding any and/or all needs.
- Customize billing based on clients needs.
- Allow access to clients paperwork via online portal
- Provide communication forms to all providers/affiliates
- Provide one time services such as placement, insurance assistance, transportation etc.
- Assist in finding financial assistance for healthcare or living related issues.
- Assist in discharge coordination in gathering paperwork that would ease the transition process.
- Connect clients with community resources
- Coordinate care for clients for up to 2.5 hours post discharge depending on facility placement.*
- Require all discharge paperwork be sent 24-48 hours prior to discharge
- Allow communication outside office hours for additional fees.*
- Educate clients to help make informed decisions.

DONT:

- Go over facility rules, regulations and paperwork with clients. (The Client and the facility owner is responsible for this) i.e admission paperwork, lease agreement, financial responsibility etc.
- Collect or discuss facility related payment with the client after move in
- Make any decisions for the clients or facility i.e medical, financial etc..
- Rehome client for 60 days post placement unless its a dire circumstance
- Cohorst clients into doing things that are not in their best interest
- Provide money or clothing to client
- Pay for clients living expenses
- Provide any hands on care
- Provide legal or medical advice to clients
- Handle clients personal affairs
- Coordinate care unless the client intake is signed

I _____the Client / Responsible party, have read and understand the care coordination relationship. I agree to adhere to these roles & responsibilities. I do understand that failure to adhere to these will result in termination of the relationship.

Signature: _____ Date:

Pricing:

List of Services	Pay As You Go	Pre-Pay
Intake + paperwork and care plan (to get started) (One time service)	**$175**	**$100**
Care Coordination*	**$18.75 per 15min ($75 per hour)**	**$15.75 per 15min ($63 per hour)**
In-person community care coordination*	**$82 for one hour then $20 per 15 min**	**$70 for one hour then $17 per 15 min**
Monthly care plan	**$70**	**$53**
Bimonthly Wellness checks	**$45**	**$30**
Monthly wellness check	**$25**	**$15**
Rush Service (3hours)	**$600**	**$475**
Text/email communication with client/family	**Free**	**Free**
After Hours Care Coordination	**$25 per 15 min**	**$22 per 15 min**

Priority Care Coordination

- **2 hour weekly Care coordination -** Telephone or electronic communication regarding client care with third parties. ($480/ month)
- **In-person Community Care Coordination-** In person visits to third parties location to ensure proper communication regarding clients care.
- **Monthly In person care plan-** Monthly care plans to set coordination goals. To address all of clients needs ($50/month)*
- **Access to portal 24/7-** Clients and loved ones would be able to access their loved ones files through SimplePractice Each client will be able to get their one login and be able to communicate with staff.

(Total monthly average:$670)*

Client Needs:

- ☐ Pay as you go
- ☐ Pre-pay (starting amount_____)
- ☐ Rush Service
- ☐ $670/month
- ☐ $1332/2 months
- ☐ $2368/4 months

I _____, would like to choose the above payment option for care coordination. I understand that these prices are subject to change based on individual needs. I understand that OSHS will utilize the funds for said coordination until the funds are depleted or allotted time is exhausted. I also understand that I can cancel this agreement at any time. Taxes and fees may apply. NO REFUNDS WILL BE GIVEN. If a client is no longer in care any/all remaining funds will be used as a credit for future services. If a client has a Representative Payee client will need to allow the representative to give Bank card information for payment. Signature and date _____

Credit Card Payment Authorization Form

Instructions: to pay by card please complete both sections below. Provide picture of Identification and card that you will be using for payment

Credit Card Holder Information

Please check credit card type:

____Visa _____ Mastercard _____ Discover _____Zelle

Credit Card Number:_____

exp. date: __/___(mm/yy) code_____ (on the back of card)

Please Indicate below the name of the card holder and the billing address

Full Name: _____ (as it appears on credit card)

Card Holder Billing Address:_____

City _____ State _____ Zip Code _____

Primary Phone Number : (____) _____

Secondary phone number (_____) _____

Identification Card information.

Name as it appears on ID:_____

ID Number and Type:_____

Birth Date:_____(mm/dd/yyyy)

I,_____, authorized to be charged for the services provided to me by One Stop Health Shop LLC (OSHS) by above method. I am aware that I will not receive a refund for any services provided by OSHS. Receipt of payment for all transactions will be sent to me via _____ that will act as my record of payment. I understand that I am responsible for any fees from my bank for any overdrafts or return payments. I understand that I will notify OSHS of any changes to my payment information to continue services. I also understand that OSHS will automatically pull payments from this account after 30 days in delinquency.

_____Cardholder Signature DATE:_____

OSHS MEDICAL RELEASE FORM

Today's Date: _____
Clients Name: _____
Clients Date of Birth: _____

Clients Insurance information: _____

Address: _____
City, State, Zip: _____
Clients Phone Number: _____

Please send clients medical information to: Facility to Obtain/Send Records

One Stop Health Shop

PO Box #8262

Port Saint Lucie FL, 34985

Phone: 772-202-0012

Fax: 772-318-4532

Email: Contact@oshs.info

Reason for requesting records:

Client authorizes the following healthcare facility to the release/request record disclosure for continuation of care.Client understands the information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Clients understand that they may revoke this authorization at any time. Clients understand that if they revoke this authorization, they must do so in writing and present written revocation to One Stop Health Shop LLC. Clients understand that the revocation will not apply to information that has already been released in response to this authorization.. Unless otherwise revoked, this authorization will expire 180 days following the date of signature. Clients understand that authorizing the disclosure of this health information is voluntary. Clients can refuse to sign this authorization. Clients understand that clients may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. Clients understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If a client has questions about disclosure of client health information, the client can contact the authorized individual or organization making disclosure. Clients have read the above foregoing Authorization for Release of Information and do hereby acknowledge that clients familiar with and fully understand the terms and conditions of this authorization.

CLIENTS SIGNATURE: _____

DATE: _____