Letter of Agreement

Date: ____________	**From:** ________________________
To: ________________________	**Phone #:** ________________________
Company: ____________________	**Fax #:** ________________________
Fax # or Email: ______________	**Address:** ______________________
RE: __________	**Number of Pages (Including Cover):** ________

____________________ agrees to pay __________________________ for services of

____.

Start of care: ______________________through ______________________.

Patient Name: __________________________________ **DOB:** ______________

Medication: _________ Dose: _________ Frequency: _________ Cost per dose:$ _________

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Supplies/ Per Diem/ Compounding/ Pump: Total cost per day: $ ________

Nursing Visits: $ ________________

Physical Therapy Visits: $________________

Occupational Therapy Visits: $ ______________ per visit

Speech Therapy Visit: $ ______________ per visit

Total number of day(s) __________ and/ or visits __________

Date (s) of service: ________________

Total Amount Due: $ ________________

Name: ____________________	**Name:** ____________________
Signature: __________________	**Title Intake Coordinator:** ____________
Date: ______________	**Date:** ______________

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination.