## Parties

This **Service Agreement** is for:

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and is made between:

| **(Client / Client’s representative)** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |
| And  **Provider** | **WHR Allied Health** |
|  |

This Service Agreement will commence on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for a period 12 months from the date of signature (unless noted otherwise).

WHR Allied Health provide Occupational Therapiy and Physiotherapy supports which are charged at a rate of **$193.99** per hour. You may also have Therapy Assistant supports recommended and these are charged at **$86.79** per hour. Our hourly rates are reviewed and indexed annually.

When the balance has been paid for services you will be provided with a receipt via email. If you are eligible for Medicare rebates the receipt provided will enable you to make that claim. Please note that we do not assess eligibility for Medicare reimbursement.

If you would like to set a budget limit for supports being provided, please let us know at the commencement of services. This assists the therapist to prioritise action areas for the client and to avoid an ‘overspend’ on supports being provided.

Invoices are generated by WHR Allied Health on a weekly basis and can be paid via direct bank transfer or credit card (via link on the emailed invoice).

Please advise how you would like invoices to be sent:

* Post (address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: (address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Budget of services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Schedule of supports

The Provider agrees to provide the Client with supports as the clients goals agreed at initial appointment and outlined below:

Additional expenses (i.e. things that are not included as part of 1:1 therapeutic intervention) are the responsibility of the Client and are not included in the cost of the supports. These will be invoiced directly to the client where email consent has authorised the purchase of the equipment.

**Commitment to the Safety of Children and Young people**

**WHR Allied Health has zero tolerance for child abuse.**

WHR Allied Health is committed to providing a safe environment where children and young people are safe and feel safe, and their voices are heard about decisions that affect their lives. Particular attention will be paid to the cultural safety of Aboriginal children and children from culturally and/or linguistically diverse backgrounds, as well as the safety of children with a disability.

Every person involved in WHR Allied Health has a responsibility to understand the important and specific role he/she plays individually and collectively to ensure that the wellbeing and safety of all children and young people is at the forefront of all they do and every decision they make.

## Costs of Services

All services are charged at the rates outlined on page one of this document.

Supports that are provided to clients that will be invoiced can include:

* Assessment (Standardised/non standardised) and associated completion of reports  –  Initial assessment reports, Intervention plans, progress reports, standardised assessment reports
* Provision of interventions.
* Maintenance of health records (notes/documentation) as required by law.
* Travel to/from client related sessions. *Please note that travel is apportioned to clients to limit this cost where possible.*
* Development of resources for the individual.
* Contact with families, other treaters, schools, suppliers. This includes all forms of communication – phone, email, fax, case conferences.
* Development/modification of Therapy Assistant programs for individuals
* Reviewing client reports (provided by other treaters).
* Late notice cancelled sessions or no shows.

*Contact with our administration team, simple referral intake, contact with financial intermediaries, arranging/confirming appointments, development of non client specific/customised resources do not attract charges.*

The majority of supports provided by WHR Allied Health therapists will be provided in a client’s home, within their local community or at our clinics – 40 Baines Cres, Torquay or Level 1/438 Dean St, Albury. This Service Agreement between WHR Allied Health and the client details that travel costs are to be claimed. Travel is charged to cover costs of getting to and from community based clients and recognises that we are unable to be providing supports to other clients at this time. We endeavour to minimise these costs (noting that we’d much prefer to be seeing clients than sitting in the car) and will group OT’s with clients in the same geographical area as best we can. In these instances, travel is shared evenly (apportioned) among clients.

**Responsibilities of Provider**

The Provider agrees to:

* Once agreed, provide supports that meet the Client’s needs at the Client’s preferred times.
* Communicate openly and honestly in a timely manner
* Treat the Client with courtesy and respect
* Consult the Client on decisions about how supports are provided
* Give the Client information about managing any complaints – ‘How to make a complaint.’
* Listen to the Client’s feedback and resolve problems quickly
* Give the Client as much notice as possible if the Provider has to change a scheduled appointment to provide supports.
* Give the Client the required notice if the Provider needs to end the Service Agreement (see ‘[Ending this Service Agreement](#_Ending_this_Service)’ below for more information)
* Protect the Client’s privacy and confidential information
* Provide supports in a manner consistent with all relevant laws, keep accurate records on the supports provided to the Client, and
* Issue regular invoices and statements of the supports delivered to the Client

## Responsibilities of client

The client agrees to:

* Inform the Provider about how they wish the supports to be delivered to meet the Client’s needs
* Treat the Provider with courtesy and respect
* Talk to the Provider if the Client has any concerns about the supports being provided
* Give the Provider a minimum of 24 hours’ notice if the Client cannot make a scheduled appointment; and if the notice is not provided by then, the Provider’s cancellation policy will apply (See below)
* Give the Provider the required notice if the Client needs to end the Service Agreement (see ‘[Ending this Service Agreement](#_Ending_this_Service)’ below for more information), and

## Students

WHR Allied Health are committed to supporting tertiary students expand and develop their skills. On occasions your therapist may have an Allied Health student observing your sessions and assisting in providing supports/interventions. At all times, the student will be acting under the supervision of a qualified Therapist. If you do not wish for this to occur, please advise your therapist.

## Payments

The Provider will seek payment for their provision of supports within a week after they are provided.

* After providing those supports, the Provider will send the Client an invoice for those supports for the Client to pay. The invoice outlines dates, duration and types (of supports provided (including travel to and from the Torquay office, report writing, liaison with parties relevant to supports).
* The Client/Client’s Nominee will need to advise the Provider if they have a preference for invoices to be posted or received by email. The Client will pay the invoice by cheque/cash/direct deposit or via online credit card payment within 14 days of the invoice being provided to the client

## WHR Allied Health Cancellation Policy

As per the ‘Responsibilities of the Client’ clients are required to provide a minimum of 24 hours’ notice if the Client cannot make a scheduled appointment. Providers may charge for participant cancellations for therapeutic supports. Appointments that are cancelled with at least 24 hours’ notice will be rescheduled at a time convenient to both parties and no charges will apply.

## Changes to this Service Agreement

If changes to the supports or their delivery are required, the Parties agree to discuss and review this Service Agreement. The Parties agree that any changes to this Service Agreement will be in writing, signed, and dated by the Parties.

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## Ending this Service Agreement

Should either Party wish to end this Service Agreement they must give 2 weeks’ notice.

If either Party seriously breaches this Service Agreement the requirement of notice will be waived.

## Feedback, complaints and disputes

### If the Client wishes to give the Provider feedback including advice that they are unhappy with the service, the Client or their family can talk to Brad Dent (WHR Allied Health Managing Director) on 0422 573 795, by email: [Brad@whralliedhealth.com](mailto:Brad@whralliedhealth.com) or by mail: WHR Allied Health Feedback (PO Box 895, Torquay, Vic, 3228). You should also know that It’s OK to complain and if you need advice or assistance to resolve a complaint about our service and haven’t been happy with our response, you can access independent support fromthe [Health Complaints Commissioner](https://hcc.vic.gov.au/) in Victoria - <https://hcc.vic.gov.au> or the [Health Care Complaints Commission](http://www.hccc.nsw.gov.au/Home) in NSW.

## Contact details

The Client can be contacted on:

| **Contact details** | |
| --- | --- |
| **Address** |  |
| **Alternative contact person** |  |

The Provider can be contacted on:

| **Contact name** |  |
| --- | --- |
| **Mobile** |  |
| **Email** |  |

## OR

| **Contact name** | Noelani Le Nevez and Bridget Longley (Administration) |
| --- | --- |
| **Mobile** | 0431 556 720 |
| **Landline** | 03 5261 9037 |
| **Email** | [Admin@whralliedhealth.com](mailto:Admin@whralliedhealth.com) |

## 

## Agreement signatures

The Parties agree to the terms and conditions of this Service Agreement.

|  |  |  |
| --- | --- | --- |
| Signature of [Client / Client’s representative] |  | Name of [Client / Client’s representative] |

|  |
| --- |
| Date |
|  | |  |  |
| Signature of authorised person WHR Allied Health (The Provider) | |  | Name of authorised person from WHR Allied Health (The Provider) |
|  |
| Date |

A scanned copy of this completed form will be provided to the client.

### Your authority for the collection and distribution of relevant information

**I**, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full name)

**Of** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Address)

**Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

am being provided with services by WHR Allied Health and by signing this document

am agreeable to the following detail (completing the relevant sections as required):

**Name** (Participant/Client /guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed by** (Participant/Client /guardian):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In the presence of:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of witness:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verbal Consent provided by client/parent/guardian

***Email/SMS consent will also be deemed as acceptable where this communication method is preferred. The relevant confirmation type will be saved within the clients file.***

### Privacy Statement

WHR Allied Health will only collect, use or disclose your personal information in accordance with the 13 Australian Privacy Principles of the Privacy Amendment (Enhancing Privacy Protection) Act 2012 and the 10 Information Privacy Principles, which are the practical core of the Information Privacy Act 2000 (Victoria). Within this document, Health Information has the meaning given in the Health Records Act 2001 (Vic); Personal Information and Sensitive Information have the meanings given in the Information Privacy Act 2000 (Vic).

WHR Allied Health will at all times, endeavour to ensure that you are informed in relation to all services provided, and instances of us requesting information from third parties. We will provide options that may be available and disclose our opinion on their advantages and disadvantages, including what is likely to happen if nothing is done. We will also make recommendations in relation to the supports provided. We will disclose any perceived risk, and the seriousness of this risk.

Sensitive waste management (Participant and Organisational Records)

To reduce risks of data breach (where personal information is accessed by someone unauthorised):

* Shredding is completed onsite at each of the WHR Allied Health offices.
* The shredded paper is placed into compost bins.
* Printed material containing personal or confidential information is not disposed of in general waste.
* Computers, computer storage, mobile phones, media and USB memory keys used to store personal information are disposed of by using a qualified secure E-waste service.

**I authorise and consent to WHR Allied Health requesting, discussing, providing and obtaining Health Information about me from any third party, including the National Disability Insurance Agency, who hold such information; and using such Health Information, for the purposes of providing services to me. I understand that the Health Information may be required for the purposes of assisting to provide my supports and services**

**I authorise and consent to a photocopy or scanned electronic version of this authority being sufficient evidence of my authority and consent to discuss or provide the Health Information requested.**

Where the service is being provided to someone under the age of 18, or where the participant/client is not perceived to have the capacity to consent, this document can be completed by a parent/guardian or a person responsible under the Guardianships and Administration Act 1986 (Vic).

I understand that I may request access to Health Information about me that is held by WHR Allied Health on 03 5261 9037, save to the extent that the WHR Allied Health is required or authorised by law to refuse to provide access.

Partial Consent

Where there are instances of partial consent (i.e. Participant/Client provides permission to speak with their treating GP, but not their Physiotherapist) the Participant/Client (or the person responsible) can provide this detail below:

Authority and consent *not* provided to WHR Allied Health to speak with:

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Specific Consent

Where there are instances of specific consent (i.e. Participant/Client provides permission to speak with their school) the Participant/Client (or the person responsible) can provide this detail below:

Authority and consent provided to WHR Allied Health to speak with:

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed by** (Participant/Client /guardian):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** (Participant/Client /guardian):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Verbal Participant/Client Consent

*(Worker/Practitioner Use Only)*

*Verbal consent should only be used where it is not practicable to obtain written consent*.

I have discussed with the consumer/consumer’s authorised representative how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

**Signed by Consultant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Consultant:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_