H & M HEALTH SERVICES, INC.
DAILY VISIT RECORD

Patient Name:_____ Special Instructions: _____
Address: _____
City: _____
Phone Number: _____

Discipline: (please circle) RN ` LPN ` PT ` PTA ` ST ` OT ` MSW ` CNA ` HHA
Insurance: (please circle) AVMED ` CARE PLUS ` CORVEL ` FREEDOM ` HUMANA ` MEDICA
PCP ` PRIVATE ` SEMINOLE ` UNITED HEALTH CARE ` VISTA

EMPLOYEE NAME: (Please Print) _____

I verify that the information and signatures contained on this sheet are correct. Falsification may result in termination of employment and prosecution.

EMPLOYEE SIGNATURE: _____

	DATE	VS CODE	TIME IN	TIME OUT	HOURS	PATIENT SIGNATURE
MON.						
TUE.						
WED.						
THUR.						
FRI.						
SAT.						
SUN.						
TOTAL VISITS:				TOTAL HOURS:		

VISIT CODES

SNEIC	INITIAL EVALUATION	PTIE	PT INITIAL EVAL
SNRNV	RN VISIT	PT	PT VISIT
SNHTV	RN HIGH-TECH	PTDC	PT DISCHARGE
SNLPN	LPN VISIT	STIEC	ST INITIAL EVAL
SNDC	NURSING DISCHARGE	ST	ST VISIT
MSIEC	MSS INITIAL EVAL	STDC	ST DISCHARGE
MS	MSS FOLLOW-UP VISIT	OTIEC	OT INITIAL EVAL
AI	AIDE VISIT	OT	OT VISIT

The undersigned agrees to pay H & M Health Services, Inc. upon demand the sum of $5,000 as liquidated damages if our employee is hired within ninety (90) days of termination of services. I hereby certify that the above named employee has performed satisfactory services for us for the hours indicated and authorize you to bill us for such services. The undersigned also agrees to pay invoice upon receipt. Interest at the rate of 1 1/2 % per month (18 % annual rate) will be charged on all past due amounts, together with reasonable attorney's fees for cost of collection.

Comments: _____

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PATIENT'S SIGNATURE (Or Authorized Representative)