Medical Service Agreement

Date: [Insert Date]

Parties:

[Provider Name]
[Provider Address]
[City, State, Zip Code]

AND

[Client Name]
[Client Address]
[City, State, Zip Code]

1. Services Provided

The Provider agrees to provide the following geriatric care services to the Client:

- Comprehensive geriatric assessment
- Personalized care plans
- Regular health check-ups
- Medication management
- Support with daily activities

2. Term of Agreement

This Agreement shall commence on [Start Date] and shall continue until [End Date], unless terminated earlier in accordance with Section 6 of this Agreement.

3. Compensation

The Client agrees to pay the Provider a fee of [Insert Fee] per [hour/session/month] for services rendered under this Agreement.

4. Responsibilities of the Provider

The Provider agrees to:

- Provide services in a professional manner.
- Maintain confidentiality of the Client's health information.
- Communicate any changes in the Client's condition to appropriate parties.

5. Responsibilities of the Client

The Client agrees to:

- Provide accurate health information to the Provider.
- Follow the care plan established by the Provider.
- Make payments in a timely manner.

6. Termination

Either party may terminate this Agreement upon [Insert Notice Period] written notice to the other party.

7. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of [State].

IN WITNESS WHEREOF

The parties hereto have executed this Medical Service Agreement as of the day and year first above written.

Provider Signature: _____

Client Signature: _____