WOUND CARE SERVICES AGREEMENT

AHADI HEALTH WOUND CARE

This Wound Care Services Agreement ("Agreement") is entered into on _____, by and between:

FACILITY	PROVIDER
Facility Name: _____	**Ahadi Health Wound Care, LLC**
Address: _____	Name: _____
Phone: _____	Address: _____
Name of Person Signing: _____	Phone: _____

1. SCOPE OF SERVICES

Provider shall provide medically necessary wound care services to Facility residents. Services include wound assessment, treatment planning, debridement, monitoring, documentation, and coordination of care. Provider services are limited to wound care and do not constitute primary medical care.

2. MEDICARE BILLING & REIMBURSEMENT

Provider shall bill resident's insurance directly for covered professional services rendered to eligible residents under Provider's own NPI.

Facility shall not submit claims for Provider's professional wound care services.

Reimbursement is subject to Medicare coverage rules, medical necessity, and documentation requirements.

3. FACILITY COMPENSATION RESTRICTIONS

No remuneration shall be paid by Facility to Provider for services billable to Medicare, except as permitted under applicable federal and state laws, including the Anti-Kickback Statute and Stark Law.

This Agreement is intended to comply with all applicable safe harbor provisions.

4. PROVIDER STATUS

Provider is an independent contractor and not an employee, agent, or joint venturer of Facility.

5. LICENSURE & COMPLIANCE

Provider represents that all clinicians are duly licensed in the State of Kansas, credentialed with Medicare, and compliant with CMS, HIPAA, and applicable federal and state laws.

6. FACILITY RESPONSIBILITIES

Facility shall:

- Provide reasonable access to residents, medical records, and treatment areas;
- Ensure valid physician orders and resident consent or Durable Power of Attorney consent are obtained;
- Maintain responsibility for nursing care, wound care supplies, and overall resident management.

7. DOCUMENTATION

Provider shall document all wound care services in the provider's EMAR (DocNow) and will furnish the facility with all treatment updates within 72 hours after every visit. New orders will be communicated to facility within 24 hours.

8. SUPPLIES

Facility shall provide the supplies to the patient. Provider shall provide own supplies and specialty instruments necessary for professional services.

9. INSURANCE & INDEMNIFICATION

Provider shall maintain professional liability insurance with minimum limits of $1,000,000 per occurrence.

Each party shall indemnify the other for claims arising from its own negligence or misconduct.

10. TERM & TERMINATION

This Agreement shall begin on the date first written above and will remain effective unless terminated.

Either party may terminate:

- With 30 days written notice, without cause;
- Immediately for material breach, fraud, loss of license, or exclusion from federal healthcare programs.

11. NON-EXCLUSIVITY

This Agreement is non-exclusive.

12. GOVERNING LAW

This Agreement shall be governed by the laws of the State of Kansas.

13. HIPAA, HITECH, AND PROTECTED HEALTH INFORMATION COMPLIANCE

Status of the Parties. The Facility and Ahadi Health Wound Care acknowledge that, in the performance of wound care services under this Agreement, Business Associate will create, receive, maintain, and/or transmit Protected Health Information ("PHI") on behalf of Covered Entity as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the HITECH Act, and implementing regulations at 45 C.F.R. Parts 160 and 164.

Permitted Uses and Disclosures. Business Associate shall:

- Use or disclose PHI solely for purposes of providing wound care services, care coordination, clinical documentation, billing, quality reporting, and healthcare operations as permitted under HIPAA;
- Not use or disclose PHI in any manner that would violate HIPAA.

14. ENTIRE AGREEMENT

This document constitutes the entire agreement between the parties.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

FACILITY REPRESENTATIVE

Name: _____

Title: _____

Signature: _____

Date: _____

PROVIDER REPRESENTATIVE

Name: _____

Title: _____

Signature: _____

Date: _____