Pediatric Live Photography Program Package
Overview of Program and Agreement

The *Hospice & Palliative Care Foundation* is pleased to offer live photography sessions for making keepsake photographs. The patient and their family will be allowed to choose a photographer that works in their area or is a preference of choice. The photographer will be required to have an established business and reputation in the community. No amateur photographers will be allowed. Once the patient and their family have chosen their preferred photographer, the following information will need to be provided. Missing or incomplete information could delay the approval process and/or the scheduling of the photography session.

PLEASE READ CAREFULLY BEFORE PROCEEDING:
BOTH THE PHOTOGRAPHER AND THE PATIENT'S FAMILY WILL NEED TO READ THIS ENTIRE AGREEMENT AS IT DETAILS THE RESPONSIBILITIES AND REQUIREMENTS FOR ALL PARTIES INVOLVED INCLUDING THE *HOSPICE & PALLIATIVE CARE FOUNDATION,* AND THOSE ACTING BEHALF OF THE *HOSPICE & PALLIATIVE CARE FOUNDATION.*

The *Hospice & Palliative Care Foundation* agrees to make a payment of no more than $200.00 for professional photography services that are provided to a pediatric hospice or palliative care patient. The chosen photographer agrees to provide photography services as a contract vendor on behalf of the *Hospice & Palliative Care Foundation*.

The $200.00 contracted price will include the following:

- One (1) hour photography session in the patient's home or agreed upon location by the patient's family and the photographer.
- Fifteen (15) to twenty (20) professionally edited photographs of the patient on a jump drive.
- Providing said jump drive to the patient, which includes the cost of mailing.
- Gas and travel time to and from the location of the photography session.

Prior to approval, the chosen photographer must complete the *Photographer Voucher Payment Process Authorization Form* (to be provided by the *Hospice & Palliative Care Foundation*). The form outlines our policy and additional requirements for paying contract vendors.

Terms Of Use:

- The photographer will provide two (2) photographs to the *Hospice & Palliative Care Foundation* by emailing them to info@hpcfoundation.org. This "two photograph" requirement will serve as proof that the photography session took place.
- The *Hospice & Palliative Care Foundation* will own the "two photographs" provided by the photographer perpetually keeping them for our records. The patient or the patient's family can give us permission to use the "two photographs" in marketing or other promotional materials, including but not limited to, publication on one or more of our social media platforms. The patient or the patient's family will need to read and indicate their selection in the section entitled *Authorization To Use Prints*.

- The *Hospice & Palliative Care Foundation* requests that any publicity or promotion from the contracted photographer, family of the patient, or anyone else using the photographs produced as a result of this agreement, acknowledge that the *Hospice & Palliative Care Foundation* and our *Pediatric Care Program* provided the funding for said photography session and the photographs, and include a link to our website (www.hpfoundation.org).
- The *Hospice & Palliative Care Foundation* agrees to give credit to the contracted photographer on any and all photographs used to promote the *Pediatric Care Program.*

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Photographer Section - -
**This section is to be completed by the photographer of choice, not the hospice team member or the patient's family.*

Photographer's Name: ____

Photographer's Address: ____
Street

___________________________ _____________________ _________________________
City State Zip Code

Photographer's Phone Number: ____
(with area code)

Photographer's Email Address: ____

Photographer's Facebook Link: ____

Once the photographer of choice has completed their sections of this agreement, the photographer will need to forward a copy of this agreement along with the *Photographer Voucher Payment Process Authorization Form* to the *Hospice & Palliative Care Foundation.* There are two options (a) via email to info@hpcfoundation.org or (b) by fax to 1-864-751-5326. **Note: please do not send pictures of the agreement and forms, we can only accept originals or scanned copies of the agreement and form.**

If sending by email, please indicate the patient's last name on the subject line. Please do not include the patient's full name or any other patient related information in an email or fax submission. Once the *Hospice & Palliative Care Foundation* has verified the agreement and forms, we will forward the agreement to the patient's family for completion. After the patient's family has completed their sections and at least two approval levels have been obtained, we will contact the photographer so they may begin setting up the session date and time.

DISCLAIMER STATEMENTS – PLEASE READ CARERFULLY BEFORE SIGNING:

Since the patient and their family will be choosing their photographer of choice, and as a contracted vendor, not an employee or volunteer, the *Hospice & Palliative Care Foundation* will not be liable for any criminal and/or civil damages incurred by the patient or their family before, during, or after the photography session. The *Hospice & Palliative Care Foundation* will also not intervene in any collection of funds for services agreed upon in excess of our maximum program limit per patient of

$200.00. Any arbitration or legal involvement will need to be conducted by the photographer and/or the patient and their family.

Photographer's Name (Print): ____

Photographer's Signature: ____

Date Signed: ____

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Patient/Patient's Family Section - -

Pediatric Patient's Name: ____

Pediatric Patient's Address: ____
Street

____________________________ ______________________ __________________________
City State Zip Code

____ _______________________________________
Patient's County Is this patient a veteran or a child of a veteran?

Pediatric Patient's Parent (s) / Legal Guardian (s) Name (s): _____________________________________

Parent (s) / Legal Guardian (s) Phone Number: ____
(with area code)

Parent (s) / Legal Guardian (s) Email Address: ____

Authorization To Use Prints –

Please select one of the following options by placing a check mark on the line provided:

_____I hereby grant the *Hospice & Palliative Care Foundation* permission to use my and/or my child's likeness in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration. I also understand HPCF is under no obligation to notify myself, my child, or any other family member of the use of these photographs at any point in time.

I understand and agree that these materials will become the property of HPCF and will not be returned. I hereby irrevocably authorize HPCF to edit, alter, copy, exhibit, publish or distribute these photos for purposes of publicizing their services and programs or for any other lawful purpose.
In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my child's or my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge HPCF from all claims, demands, and causes of action which I, my heirs,

representatives, executors, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

_____ I request that the *Hospice & Palliative Care Foundation* **NOT** use photographs provided for our photography package for the promotion of the *Pediatric Care Program* or other HPCF programs.

Photography Package For ____
(Patient name)

DISCLAIMER STATEMENTS – PLEASE READ CARERFULLY BEFORE SIGNING:

Since the patient and their family will be choosing their photographer of choice, they bear all responsibility and liability in vetting the photographer and their company before completing these forms. The *Hospice & Palliative Care Foundation* will not be liable for any criminal and/or civil damages incurred by the photographer, their equipment, and/or their staff.

The *Hospice & Palliative Care Foundation* will not be responsible for any photography fees or service fees beyond the maximum photography package gift amount of $200.00. If the family chooses to obtain additional prints and/or services from their chosen photographer, they will be responsible for any amounts over the $200.00 maximum photography package gift amount. This has been explained to the photographer of choice as part of the voucher-payment process.

As part of this program, the patient and their family must have two (2) photographs supplied by their photographer of choice. The patient and their family have the option to decide if the *Hospice & Palliative Care Foundation* may use the "two photographs" provided as part of their marketing endeavors. See foregoing sections.

Individuals requesting gifts and relief funds on behalf of a minor patient must be the patient's parent (s) or legal guardian (s). We cannot accept requests from family members or friends unless they have been granted legal guardianship by a family court judge.

Signature Lines for Pediatric Patients Age 18 or Older:

I certify that I am eighteen (18) years of age or older, and that I am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

If the patient received assistance completing this application on behalf of the patient by a member of the patient's healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on the patient's behalf.

____ _______________________
(Signature) (Date)

____
(Printed Name)

Signature Lines for Parent (s) or Legal Guardian (s):
Note: this is for patients under the age of eighteen (18) and/or incompetent to contract in their own name

If the parent (or legal guardian) received assistance completing this application on behalf of the patient by a member of the patient's healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on the patient's behalf.

I hereby certify that I am the parent (s) or legal guardian (s) of _______________________________, and do hereby give consent without reservation on behalf of this person.

____ _______________________
(Parent/Guardian Signature) (Date)

____
(Printed Name)

____ _______________________
(Parent/Guardian Signature) (Date)

____
(Printed Name)

Hospice Team Member Please Sign Below In The Box:

For Administration and Accounting Use Only:

Level One (Hospice Worker):____**Date:**__________

Level Two Approver (Associate Director):_____________________________________**Date:**__________

Level Three Approver (Accounting):____**Date:** __________