

Ambulance Signature Form – Version 1.5

Patient Name: _____ **Transport Date:** _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to the Berkeley County Emergency Ambulance Authority for any services provided to me by Berkeley County Emergency Ambulance Authority now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Berkeley County Emergency Ambulance Authority, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Berkeley County Emergency Ambulance Authority any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Berkeley County Emergency Ambulance Authority. I authorize Berkeley County Emergency Ambulance Authority to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to Berkeley County Emergency Ambulance Authority and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Berkeley County Emergency Ambulance Authority, now, in the past, or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received Berkeley County Emergency Ambulance Authority’s Notice of Privacy Practices.

Signature Section:

ONE of the following three sections MUST be completed.

<p align="center"><u>SECTION I – PATIENT SIGNATURE</u></p> <p>The patient must sign here unless the patient is physically or mentally incapable of signing.</p> <p>X _____ Patient Signature or Mark Date</p> <p align="center">If the patient signs with an “X” or other mark, Someone should sign below as witness. This can be an ambulance crew member.</p> <p>X _____ Witness Signature Date</p> <hr/> <p>Witness Printed Name</p> <p>NOTE: if the patient is a minor, the parent or Legal guardian should sign in this section.</p>	<p align="center"><u>SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE</u></p> <p align="center">Complete this section <u>only</u> if the patient is physically or mentally incapable of signing.</p> <p>Reason the patient is physically or mentally incapable of signing:</p> <hr/> <p>Authorized representatives include <u>only</u> the following individuals (check one):</p> <p><input type="checkbox"/> Patient’s Legal Guardian <input type="checkbox"/> Patient’s Health Care Power of Attorney <input type="checkbox"/> Relative or other person who receives government benefits on behalf of patient. <input type="checkbox"/> Relative or other person who arranges treatment or handles the patient’s affairs <input type="checkbox"/> Representative of an agency or institution that furnished care, services or assistance to the patient.</p> <p><i>I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered to the patient.</i></p> <p>X _____ Representative Signature Date Printed Name of Representative</p> <hr/> <p>Representative’s Address</p>
<p align="center"><u>SECTION III – AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES</u></p> <p>Complete this section <u>only</u> if: (1) the patient was physically or mentally incapable of signing, <u>and</u> (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.</p> <p>A. Ambulance Crew Member Statement (<u>must</u> be completed by crew member <u>at time of transport</u>) <i>My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. My signature is not an acceptance of financial responsibility for the services rendered to this patient.</i></p> <p>Reason patient is incapable of signing: _____ Name and location of receiving facility: _____</p> <p>X _____ Signature of Crewmember Date Printed Name of Crewmember</p> <p>B. Receiving Facility Representative Signature <i>The patient named on this form was received by this facility on the date indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.</i></p> <p>X _____ Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative</p>	