Agency ID: 1011 | Call # | Booklet ID | Image Type: 2

Do not attach anything Above this area

Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility: I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. **Patient:** ☐ **Unable to Sign** ☐ **Refused to Sign** ☐ **PCS Collected** ☐ **Other Insurance Collected**

Authorization Signature: Date:	Guarantor Signature:
Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information:	Privacy Notice Signature: Date:

Patient's Physician Name (please print):	Receiving RN / MD Signature:	Technician Signature: Date

I Refuse Treatment / Transportation and understand the consequences of my refusal:	Witness Signature for Refusal:	On-Line Medical Control Signature:

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If Patient is unable to sign, complete sections below as needed

SECTION I – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing: _____

Authorized representatives include **only** the following individuals (check one):

- ☐ Patient's Legal Guardian
- ☐ Patient's Health Care Power of Attorney
- ☐ Relative or other person who receives government benefits on behalf of patient
- ☐ Relative or other person who arranges treatment or handles the patient's affairs
- ☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

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.

X _____ _____

Representative Signature Date Printed Name of Representative

- OR –

SECTION II - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

You must complete Section A for all patients if you did not complete Signatures or Section I above. You must ALSO complete EITHER B. or C.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

I am verifying with my initials below that I signed the ePCR at the time of service. The patient named above was physically or mentally incapable of signing, and none of the authorized representatives listed in Section I of this form were available or willing to sign on the patient's behalf.

Reason patient incapable of signing: _____

Name and Location of Receiving Facility: _____

Time at Receiving Facility: _____

X _____ _____

Crew Member **Initials** Printed Name of Crew Member

B. Receiving Facility Representative Signature

The above-named patient was received by this facility at the date and time indicated above. ***Sign on the ePCR.***

X _____ _____

Receiving Facility Representative **Initials** Printed Name and Title of Receiving Facility Representative Date

C. Secondary Documentation

If **NO** facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility) ☐ Facility Face Sheet/Admissions Record

☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record

Do not attach anything below this area

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