Cole Camp Ambulance District

Patient Signature Form

Patient Name:_____ **Transport Date:** ____/____/____ **Incident Number:**_____

*This form **MUST** be completed on **ALL** patient transports*

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to me by Cole Camp Ambulance District (CCAD) now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by CCAD, 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 CCAD any payments that I receive directly from insurance or any other source whatsoever for the services provided to me and I assign all rights to such payments to CCAD. I authorize CCAD 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 CCAD 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 CCAD now, in the past, or in the future.

X_____ _____ X_____ _____

Patient Signature or Mark | Date | Witness Signature | Date

_____

Printed Name of Witness

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE / CREW MEMBER SIGNATURE

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

On the line below explain the circumstances that make it impractical for the patient to sign:

_____

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by CCAD now or in the past, or in the future, where permitted. By signing below, I acknowledge that I am one of the authorized signers below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

___ Patient's legal guardian
___ Relative or other person who receives social security or other governmental benefits on behalf of the patient
___ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's care
___ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e. ambulance services) but Furnished other care, services, or assistance to the patient

_____ _____ _____

Representative Signature | Date | Printed Name and Address of Representative

Complete this section **only** if: (1) The patient was physically or mentally incapable of signing, **and** (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

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.**

_____ _____ _____

Crew Member Signature | Date | Printed Name and Title of Crew Member

SECTION III – AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

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

Name and Location of Receiving Facility: _____

Time at receiving facility: _____

_____ _____ _____

Signature of Crew Member | Date | Printed Name and Title of Crew Member

B. Receiving Facility Representative Signature (Must be signed for ALL transports)

The patient named above on this form was received at this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

_____ _____ _____

Signature of Receiving Facility Representative | Date | Printed Name and Title of Receiving Facility Signature