Canyon County Ambulance District Signature Form

Incident Number:

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

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Canyon County Ambulance District (CCAD) provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

A copy of this form is valid as an original

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 request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to CCAD for any services provided to me by CCAD now, in the past, or in the future. 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 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.

If the patient signs with an "X" or other mark, a witness should sign below

X _____ _____ X _____ _____
Patient Signature or Mark | Date | Witness Signature | Date

SECTION II - AUTHORIZED REPRESENTATIVE 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 payor 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 listed 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 exercise other responsibility for the patient's affairs
- ☐ 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

X _____ _____ _____
Representative Signature | Date | Printed Name and Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

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.

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

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.**

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

_____

Name and Location of Receiving Facility: _____

Time at Receiving Facility: _____

X _____ _____ _____
Signature of Crewmember | Date | Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by 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.**

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