PATIENT AUTHORIZATION, RELEASE AND NPP ACKNOWLEDGEMENT

I, the undersigned, hereby consent to medical treatment by Trans-Care Ambulance

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Trans-Care for any services provided to me by *Trans-Care* now, in the past or in the future. I understand that I am financially responsible for the services and supplies provided to me by *Trans-Care*, 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 *Trans-Care* 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 *Trans-Care*. I am aware that Medicare or Medicaid may be likely to deny payment for services not medically necessary. I agree to be personally and fully responsible for payment of such denied claims by either Medicare or Medicaid. I authorize and direct any holder of medical information or documentation about me to release such information to *Trans-Care* and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by *Trans-Care*, now, in the past or in the future. I authorize *Trans-Care* to appeal payment denials or other adverse decisions on my behalf without further authorization. I understand that I am financially responsible to *Trans-Care* for charges not covered by this authorization, and hereby guarantee payment of this bill. I further agree that if collection is made by suit, or otherwise, I will pay all collections costs(currently 40% of charges) and including reasonable attorney fees**.** I also agree that we or our agents may contact you by telephone at any telephone number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, applicable. I have read this disclosure and agree that Trans-Care or its agents may contact me as above. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received *Trans-Care's* Notice of Privacy Practices.

SIGNATURE SECTION:

One of the following three sections **MUST** be completed.

SECTION I – PATIENT SIGNATURE

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

X_____
Patient Signature or Mark

If the patient signs with an "X" or other mark, it is required that someone sign as a witness.

X_____
Witness Signature

X_____
Witness Printed Name

If patient is physically or mentally incapable of signing, Section II must be completed.

SECTION II – 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 Printed Name of Representative

If no one above is available or willing to sign, Section III must be completed.

SECTION III -- NO ONE AVAILABLE OR WILLING TO SIGN:

Complete this section only for emergency responses **and** if patient was physically or mentally incapable of signing **and** no authorized representative (as listed in Section II) was available or willing to sign on the patient's behalf.

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 on this report 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.

Reason Patient incapable of signing: _____

Name and location of Receiving Facility: _____

X_____ _____
Crewmember Signature Printed Name of Crewmember