

SECTION I – AUTHORIZATION FOR BILLING (PATIENT ABLE TO SIGN)

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Waller County EMS for any service provided to me by Waller County EMS now or in the future. I understand that I am financially responsible for the services provided to me by Waller County EMS, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which is paid by my insurance. I agree to immediately remit to Waller County EMS 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 Waller County EMS. I authorize to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Waller County EMS 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 Waller County EMS, now or in the future. A copy of this form is as valid as an original. **Privacy Practices Acknowledgement:** by signing below, I acknowledge that I have received Waller County EMS notice of Privacy Practices.

Printed Name: _____ Signed: _____

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE (PATIENT NOT ABLE TO SIGN)

Complete this section ***only*** if 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 the 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.

Printed Name: _____ Signed: _____

Reason Patient is Incapable of Signing: _____

SECTION III – EMS PERSONNEL AND FACILITY SIGNATURES (PATIENT NOT ABLE TO SIGN)

Complete this section only for emergency transports, 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 behalf of the patient at the time of the service.

My signature below indicates that, 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 II of this form were available or willing to sign on the patient’s behalf.

EMS Provider: _____ Printed: _____

Reason Patient is incapable of Signing: _____

Facility Provider Receiving Patient: _____

Printed Name: _____ Title: _____

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PROVIDER SIGNATURE: _____ **TITLE** _____ **DATE:** ____/____/____