

**Patient Name:** \_\_\_\_\_ **Transport Date:** \_\_\_\_\_

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits on my behalf are paid to Midlands Medtech, LLC Ambulance (“Midland Medtech LLC”) for any services provided to me by Midlands Medtech LLC now or in the future. I understand that I am financially responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Midlands Medtech LLC 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 Midlands Medtech LLC. I authorize Midlands Medtech LLC 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 Midlands Medtech LLC 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 Midlands Medtech LLC, now or in the future. A copy of this form is a valid as an original.

**Privacy Practices Acknowledgement:** By signing below, I acknowledge that I have received Midlands Medtech LLC’s Notice of Privacy Practices

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_

**Medicare Number:** \_\_\_\_\_ **Medicaid Number:** \_\_\_\_\_

**Other Insurance Company:** \_\_\_\_\_ **Policy:** \_\_\_\_\_

**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 recommended that someone sign below 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 the 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**

**SECTION III EMERGENCIES ONLY – AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURE**

Complete this section only for emergency ambulance transports, if patient was physically or mentally incapable of signing, and no authorized representative (as listed in Section II) was available or will 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.*

Reason pt incapable of signing: \_\_\_\_\_

Name and Location of Receiving Facility: \_\_\_\_\_ Time at Receiving Facility: \_\_\_\_\_

X \_\_\_\_\_  
**Signature of Crewmember**

\_\_\_\_\_  
**Printed Name of Crewmember**

**B. Receiving Facility Representative Signature**

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

X \_\_\_\_\_  
**Signature of Receiving Facility Representative**

\_\_\_\_\_  
**Printed Name and Title of Receiving Facility Representative**

**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© 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