Montgomery County Emergency Medical Services

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

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to **Montgomery County EMS** for any services provided to me by **Montgomery County EMS** now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by **Montgomery County EMS**, 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 **Montgomery 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 **Montgomery County EMS**. I authorize **Montgomery County EMS** 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 **Montgomery County EMS** 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 Montgomery County EMS, now, in the past, or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received **Montgomery County EMS** Notice of Privacy Practices and agree to its contents.

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 Date

If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

X _____ _____
Witness Signature Date

_____
Witness Printed Name

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

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 Date Printed Name of Representative

_____
Representative's Address

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.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____ _____
Signature of Crewmember Date Printed Name 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

Notice of Privacy Practices and Insurance Release

Montgomery County Emergency Medical Services holds patient confidentiality in the highest regards, abiding by national patient privacy standards know as HIPAA (Health Insurance Portability & Accountability Act of 1996). Montgomery County E.M.S. is allowed to share your personal medical information with first responders, physicians, nurses and medical facilities that assist in providing your medical care and treatment. This information is only releases to persons acting within the official capacity of their duties. Your information also will be shared with any insurance carrier that may provide reimbursement coverage for our services. If payment of services are not received or a payment plan established within 90 days, these records can be used by Credit Bureau Systems of Clarksville for debt collection purposes as allowed by the Fair Debt Collection Practices Act.

Your records are maintained and secured within our system. Our business office is located at 1608 Haynes Street, Clarksville, TN 37043; you may obtain a copy of your records at this location Monday through Friday from 8a.m. to 4p.m. except on holidays. You will be required to present 2 forms of identification before this information is released. Records may be obtained at no charge annually; a charge of $20 will be assessed for additional copies or legal requests submitted by attorneys. Parents of children under the age of 18 will be afforded the same rights as those given to adult patients.

Within HIPPA regulations, patient records may be accessed by office personnel or administration for the purpose of QUALITY ASSURANCE/IMPROVEMENT, TRAINING, LICENSING, PUBLIC HEALTH ISSUES, HEALTH CARE FRAUD AND ABUSE DETECTION AND LEGAL SUBPOENAS.

By signing above, I acknowledge that I have received a copy of the MCEMS Notice of Privacy Practices. I also authorize release of medical information and/or records necessary to process my insurance claim(s). Also, I authorize payment of medical benefits to Montgomery County Emergency Medical Services.