Personal Care Ambulance Transport – Signature Form

Patient Name: _____ **Date:** _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Personal Care Ambulance Transport, LLC (PCAT) for any services provided to me by PCAT now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by PCAT, 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 PCAT 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 PCAT. I authorize PCAT 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 PCAT 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 PCAT, now, in the past, or in the future. A copy of this form is a valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received PCAT's Notice of Privacy Practices.

SIGNATURE SECTION: *ONE* of the following three *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 REPRESNTATIVE 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 POA
- ☐ 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 to the patient.

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 <u>at time of transport</u>)

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 to this patient.

Reason patient is incapable of signing: _____

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

X _____ _____ _____
Signature of Crewmember Date Printed Name of Crew Member

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility on 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