Patient Name: _____ **Date of Service:** _____

TRACKSIDE MEDICAL

Section 1- Patient Signature

The patient must sign here unless the patient is physically or mentally incapable of signing or is a minor child

I authorize **Trackside Medical**, its employees, agents, and authorized billing representatives to bill and receive payment for emergency medical services provided to me from any available insurance benefits, including but not limited to Medicare, Medicaid, commercial health insurance, automobile insurance (Medical Payments/PIP), Workers' Compensation, and any other applicable insurance coverage. I authorize payment of all eligible benefits directly to Trackside Medical. I assign and transfer to Trackside Medical all rights to insurance benefits payable for the services provided to me in connection with this incident. I understand that this assignment does not relieve me of responsibility for any deductibles, copayments, coinsurance, non-covered services, or other balances for which I am legally responsible under my insurance policy or applicable law. I authorize Trackside Medical to release medical records, patient care reports, billing records, and other information necessary to process insurance claims, obtain payment, respond to requests from insurance carriers, comply with Medicare, Medicaid, Workers' Compensation, or other governmental requirements, and support billing appeals or audits. This authorization includes the disclosure of protected health information as permitted under the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws. I understand that Trackside Medical will make reasonable efforts to bill my insurance; however, insurance coverage and payment are not guaranteed. I agree to provide any additional insurance information that becomes available after the date of service and understand that I remain financially responsible for any charges not paid by my insurance, except where prohibited by law or contractual agreement. I acknowledge that emergency medical services are provided under unpredictable and time-sensitive circumstances. I understand that Trackside Medical personnel will provide care in accordance with applicable medical protocols, physician medical direction, accepted EMS standards of care, and the clinical information available at the time of treatment. Except as otherwise provided by Ohio law, I acknowledge that Trackside Medical, its officers, employees, medical directors, and agents shall not be liable for outcomes resulting from the inherent risks associated with emergency medical care that is provided in good faith and in accordance with applicable standards of care. Nothing in this agreement is intended to waive or release liability for conduct that cannot legally be waived under Ohio law, including gross negligence, willful misconduct, or intentional wrongdoing. I certify that the information I have provided is true and accurate to the best of my knowledge. I have read this authorization, or it has been read and explained to me. I understand its contents and voluntarily authorize Trackside Medical to bill my insurance, release information necessary for payment, and provide the services described above.

X_____ _____ **X**_____ _____
Patient Signature **Date** **Witness** **Date**

Date **Witness** **Date**

Section 2 – Authorized Representative

Complete Only if the Patient Is Unable to Sign

Reason the patient is unable to sign:_____

Authorized Representative Status (*Check the one option that best describes your relationship to the patient)*

☐ Parent or Legal Guardian of a Minor Child
☐ Relative or Other Person Who Receives Benefits on Behalf of the Patient
☐ Relative or Other Person Who Arranges Medical Care for the Patient
☐ Representative of an Agency or Institution Responsible for Organizing the Patient's Care

Authorization I certify that I am authorized to act on behalf of the patient and that the information provided is true and correct to the best of my knowledge. I have read (or had explained to me) the Patient Authorization and Assignment of Benefits contained in Section 1 and voluntarily authorize Trackside Medical to bill all applicable insurance benefits, release medical information as necessary to process insurance claims, and receive payment for services rendered. I understand that the patient and/or the patient's responsible party may remain financially responsible for charges not paid by insurance, except where prohibited by law or contractual agreement. I further acknowledge that emergency medical services involve inherent risks and that Trackside Medical, its officers, employees, medical directors, and agents shall not be liable for outcomes resulting from emergency care provided in good faith and in accordance with applicable standards of care, except as otherwise provided by Ohio law.

Authorized Representative_____ **Signature:** _____ **Date:** _____

Section 3 – Receiving Facility Certification

Complete Only if No Patient or Authorized Representative Is Available.

This section is to be completed only when ALL of the following conditions:

*The patient is physically and/or mentally incapacitated and unable to sign; **and** No authorized representative is available or willing to sign*

By signing below, the receiving facility representative certifies that, to the best of their knowledge, the above conditions existed at the time of transport and that the patient was unable to execute the Patient Authorization.

Receiving Facility Representative.

Facility Name: _____ **Date:** _____

Printed Name: _____**Signature:** _____**Title:** _____.

EMS Provider

I certify patient was physically and/or mentally unable to sign this authorization and no authorized representative was available or willing to sign.

Printed Name: _____**Signature:** _____**Certification Level:** _____

Patient Name: _____ **Date of Service:** _____