Atlantic Coast Medical Transport, LLC

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

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to **Atlantic Coast Medical Transport. ("ACMT")]** for any services provided to me by **[ACMT]** now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by **[ACMT]**, 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 **[ACMT]** 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 **[ACMT]**. I authorize **[ACMT]** 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 **[ACMT]** 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 ACMT, 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 **[ACMT's]** Notice of Privacy Practices.

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