Ambulance Billing Authorization and Privacy Acknowledgment Form
Tri-City Ambulance Service

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

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Tri-City Ambulance Service for any services provided to me by the Tri-City Ambulance Service now or in the future. I understand that I am financially responsible for the services provided to me by the Tri-City Ambulance Service, 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 the Tri-City Ambulance Service 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 the Tri-City Ambulance Service. I authorize the Tri-City Ambulance Service 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 the Tri-City Ambulance Service 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 the Tri-City Ambulance Service, now or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I also acknowledge that I have received Tri-City Ambulance Service'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

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness.

X _____
Witness Signature

_____
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 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 SIGNATURES

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 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.

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(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility)
☐ Patient Medical Record
☐ Facility Face Sheet/Admissions Record
☐ Hospital Log or Other Similar Facility Record

TRI-CITY AMBULANCE SERVICE/ST. CHARLES FIRE DEPARTMENT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED and HOW YOU CAN GET ACCESS TO THIS INORMATION

~ PLEASE REVIEW CAREFULLY ~

Purpose of this Notice: The Tri-City Ambulance Service/St. Charles Fire Department is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information, or PHI, and to provide patients with a notice of our legal duties and privacy practices with respect to PHI. This Notice describes a patient's legal rights, the Tri-City Ambulance Service's/St. Charles Fire Department's privacy practices, and identifies how the Tri-City Ambulance Service/St. Charles Fire Department is permitted to use and disclose PHI. Uses and Disclosures of PHI: The Tri-City Ambulance Service/St. Charles Fire Department may use PHI for the purposes of treatment, payment, and health care operations, in most cases without a patient's written permission. Examples of The Tri-City Ambulance Service's/St. Charles Fire Department's use of PHI:

. . . . . For treatment: This includes use of information that we obtain pertaining to a patient's medical condition and treatment provided by the Tri-City Ambulance Service/St. Charles Fire Department and other medical personnel. It also includes information the Tri-City Ambulance Service/St. Charles Fire Department discloses to other health care personnel to whom the Tri-City Ambulance Service/St. Charles Fire Department transfers patient care and includes disclosure via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record created.

. . . . . For payment: This includes any activities the Tri-City Ambulance Service/St. Charles Fire Department must undertake in order to be reimbursed for the services provided, including such things as submitting bills to insurance companies and other billing agencies.

. . . . . For health care operations: This includes quality assurance activities, licensing, and training programs, appropriate internal investigations, processing grievances and complaints.

Other Use and Disclosure of PHI Without Authorization: The Tri-City Ambulance Service/St. Charles Fire Department may disclose PHI *without* a patient's written authorization or opportunity to object in certain situations as permitted or required by federal, state, or local law.

Any other use or disclosure of PHI, other than those listed above will only be made with a patient's written authorization. **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization**.

Patient's Rights: As a patient, you have a number or rights with respect to the protection of your PHI, including:

- Patients have a right to access, inspect, and copy most of the medical information the Tri-City Ambulance Service/St. Charles Fire Department maintains about them.
- Patients have the right to request an amendment to written medical information that the Tri-City Ambulance Service/St. Charles Fire Department may have about them.
- Patients may request an account of certain disclosures of medical information that the Tri-City Ambulance Service/St. Charles Fire Department has made about them.
- Patients have the right to request a restriction to the use and disclosure of medical information about them. Tri-City Ambulance Service/St. Charles Fire Department is not required to agree to any restrictions requested, but any restriction agreed to by the Tri-City Ambulance Service/St. Charles Fire Department is binding.

Revisions to the Notice – The Tri-City Ambulance Service/St. Charles Fire Department reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that the Service/Department maintains. To file a comment, complaint, question or request within the Tri-City Ambulance Service/St. Charles Fire Department, contact:

Director of Emergency Medical Services
St. Charles Fire Department
112 North Riverside Avenue Telephone: 630/377-4458
St. Charles, IL 60174 Fax: 630/762-7035