PLACE STICKER HERE OR:

_____
NAME

_____
DATE OF BIRTH

North East Mobile Health Services

PATIENT SIGNATURE FORM

RUN#: _____

DATE OF SERVICE: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to North East Mobile Health Services, ("NEMHS") for any services provided to me by NEMHS now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by NEMHS, 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 NEMHS 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 NEMHS. I authorize NEMHS 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 NEMHS 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 NEMHS, now, in the past, or in the future. A copy of this form is as valid as an original.

I furthermore understand that the services provided to me by NEMHS may be considered uncovered services by my insurance carrier and/or in some circumstances, may not be considered medically necessary to support the need for ambulance transportation, which may make me financially responsible for those services. Common examples of uncovered services for Medicare are transportation to or from a doctor's office, transportation past the closest appropriate facility or transportation where other means of transportation where more appropriate. I also understand that NEMHS will assess a 1% monthly interest to any balance that remains unpaid after 30 days of receiving the first invoice.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received or have been offered a copy of the NEMHS Notice of Privacy Practices handout.

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

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.

X_____ _____
Representative Signature **Date**

_____
Representative Printed Name

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 patient incapable of signing: _____

Name and Department of Receiving Facility: _____ **Time at Receiving Facility:** _____

X_____ _____ _____
Signature of Crew Member **Date** **Printed Name of Crew Member**

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 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**