Laurel Fire Department, Inc. HIPAA and NPP Signature Form

Patien	t Name:		Transport Date:	_
Fire De respon respon payme rights t withou release carrier	epartment ("LFD.") for any services provided is ible for the services provided to me by LF is ible for an amount in addition to that which ints that I receive directly from insurance of to such payments to LFD. I authorize LFD to the further authorization. I authorize and directly such information to LFD and its billing ages and agents, and/or any other payers or in	ed to me by Lift of the control of t	ry other insurance benefits be made on my behalf of FD now or in the future. I understand that I am final of my insurance coverage and in some cases, may my insurance. I agree to immediately remit to LFT whatsoever for the services provided to me and I as nent denials or other adverse decisions on my behalf medical information or documentation about mene Centers for Medicare and Medicaid Services and be necessary to determine these or other benefit future. A copy of this form is as valid as an original	ncially y be D any ssign all alf to d its
	y Practices Acknowledgment: by signing beloes at http://www.laurelfiredept.com	w, I acknowled	lge that I am able to obtain a copy of the LFD Notice of P	rivacy
	ONE of the follo	SIGNATURE wing three se	<u>E SECTION</u> : ections MUST be completed.	
This S	ECTION I – PATIENT SIGNATURE Section is for emergencies or non-emergencies. tient must sign here unless the patient is physically or mentally incapable of signing.	This section is	II – AUTHORIZED REPRESENTATIVE SIGNAT for emergencies or non-emergencies. Complete this section patient is physically or mentally incapable of signing.	
X Datiaset	Company of Mark	Authorized ren	avecantatives include and the following individuals (shock and	_
Patient Signature or Mark If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an ambulance crew member.		☐ Patient's Lec	presentatives include only the following individuals (check one gal Guardian Patient's Health Care Power of Attorney other person who receives government benefits on behalf of patient person who arranges treatment or handles the patient's a tive of an agency or institution that furnished care, services or the patient.	atient
Witness Signature		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.		
Witness Printed Name		X Representative Signature Printed Name of Representative		
Comp	plete this section only if all of the following are true: (l) the call is an e	EW AND FACILITY REPRESENTATIVE SIGNAT mergency ambulance transport, (2) the pt was physically or m as available or willing to sign on behalf of the pt at time of services.	entally
A.	Ambulance Crew Member Statement (<u>must</u> 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:			<u> </u>
	X Signature of Crewmember		Printed Name of Crewmember	
В.	Receiving Facility Representative Signatur	re		
	The patient named on this form was received by this facility at the date and time indicated above. This signature is not an acceptance of financial responsibility for the services rendered to this patient.			
	X Signature of Receiving Facility Representative		Printed Name and Title of Receiving Facility Representative	
C.				
C.	Secondary Documentation (required only if signature in Section B above cannot be obtained) f 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 indica	ates that the patie	ent was transported to that facility by ambulance on the date and the ambulance service is expressly permitted by \$164.506(c) of the control	d time
	☐ Patient Care Report (signed by representative of ☐ Patient Medical Record	• •	☐ Facility Face Sheet/Admissions Record ☐ Hospital Log or Other Similar Facility Record	