Citizens Ambulance Service
Patient Transport Form

Transport Date: _____ / _____ / 20_____

First Name: _____ Last Name: _____

Patient DOB: _____ /_____/_____ Patient SS#: _____ - _____ - _____

Privacy Practice Acknowledgement: by signing below the signer acknowledges that Citizens Ambulance Service (CAS) provided a copy of its Notice of Privacy Practices to the patient or other party or provided with instructions on where to find the Notice to the patient. ****A copy of this form is valid as an original****

SECTION 1— PATIENT SIGNATURE

The **patient** must sign here unless the patient is physically or mentally incapable of signing.

NOTE: If the patient is a minor the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by CAS now, in the past or in the future until such time as I revoke this authorization in writing I understand that I am financially responsible for the services and supplies provided to me by CAS 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 CAS 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 CAS. I authorize CAS to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to CAS 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 CAS. I also authorize CAS to obtain medical, insurance, billing and other relevant information about me from any party, database, or other source that maintains such information. ***If the patient signs with an "X" or other mark, a witness MUST sign below****

X_____ **X**_____

Patient Signature Witness Signature

SECTION II- AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section ONLY if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am Signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by CAS now, or in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an Acceptance of financial responsibility for the services rendered.**

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges or the patient's treatment or exercises other responsibility [or the patient's affairs]

X_____ **Date: _____ / _____ / 20 _____**

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY

Complete this Section ONLY if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representatives (Section II) were available or willing to sign on behalf of the patient at the time of service.

Describe the circumstances that made it impractical for the patient to sign: _____

Name and, Location of Receiving Facility: _____ Time: _____:_____

Signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by CAS.

Receiving Facility & 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 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. The patient named on this form was received by the facility on the date and at the time indicated above. ***My signature is not an acceptance of financial responsibly for the services rendered.*** ****BOTH SIGNATURES ARE NEEDED HERE****

X_____ **Date: _____ / _____ / 20 _____**

Crew Member Signature

X_____ **Date: _____ / _____ / 20 _____**

Signature of Receiving Facility Rep.