Citizens Ambulance Service Patient Refusal Form

Date: _____/_____/20_____ Patient Name: _____

DOB: _____/_____/_____ Phone #: (_____) _____-_____ SSN: _____-_____-_____

FULL Address: _____

Suspected serious injury or illness based upon patient history, mechanism of injury, or physical examination? □Yes □No

Situation of Injury/Illness: _____

18 years of age or older? □Yes □No

Any evidence of: Suicide attempt? □Yes □No Head injury? □Yes □No

Patient Oriented to:

Person □Yes □No **Place** □Yes □No **Time** □Yes □No **Event** □Yes □No

Syncope? □Yes □No **Intoxication?** □Yes □No **Chest Pain?** □Yes □No **Dyspnea?** □Yes □No

Vital Signs

Pulse: _____ BP: _____ / _____ Resp: _____ SpO2: _____% Glucose: _____mg/dl

Risks explained to patient:	□Yes □No
Patient understands clinical situation:	□Yes □No
Patient verbalizes understanding of risks:	□Yes □No
Patient plans to seek further medical evaluation:	□Yes □No

Patient Outcome

□ Patient **refused EMS assessment**

□ Patient **refused transport** to a hospital against EMS advice

□ Patient **refused transport** to EMS crew recommended hospital

□ Patient accepts transportation to hospital by EMS but **refuses any or all treatment offered**

Specify: _____

□ Patient **refused C – Spine Precautions**

□ Other: _____

This form is being provided to me because I have refused assessment, treatment and/or transport by an EMS provider for myself or on behalf of the patient list above. I understand the EMS providers are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I (or the patient) may change my mind, call 911, and/or seek treatment or assistance later. I also understand that treatment is available at an emergency department 24 hours a day. I acknowledge that this advice has been explained to me by the EMS crew and that I have read this form completely and understand its terms.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Citizens Ambulance Service now, in the past, or in the future, until I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Citizens Ambulance Service regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what was paid by my insurance. I agree to immediately remit to Citizens 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 Citizens Ambulance Service. I authorize Citizens Ambulance Service 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 Citizens Ambulance Service 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 Citizens Ambulance Service, now, in the past, or in the future. I also authorize Citizens Ambulance Service to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

_____ _____

Signature (Patient or Other) **EMS Provider Signature**

_____ _____

If other than patient, print name and relationship to patient **Witness Signature**