STPFD#11 EMS

EMS Item #_____

St. Tammany Parish Fire Protection District #11 Emergency Medical Services
64279 Hwy 3081 / P.O. Box 1210 Pearl River, LA 70452 *Office Telephone: (985) 863-3132*

Required Patient Signature Form For…

1. **Patient financial responsibility for payment due for services rendered…**
   I acknowledge that I am legally responsible for the emergency services provided to me by STPFPD#11 EMS regardless of insurance benefits or coverage. I agree to remit any payments immediately to STFPD#11 EMS that I might receive directly from any source for emergency services that was provided to me. I understand that I am financially responsible to STFPD#11 EMS and agree to remit payment for services rendered to me if no health insurance benefits are available to me.
2. **Billing insurance authorization…**
   I request that any payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to STFPD#11 EMS for services rendered to me. I hereby authorize my health insurance carrier to remit any payment for services rendered to STFPD#11 EMS.
3. **Release of medical information for insurance and billing purposes…**
   I authorize and direct any holder of medical information or documentation concerning me to the release to the Centers for Medicare Services and its carriers or agents, UNISYS/ Medicaid services, my private insurance carrier, as well as STFPD#11 EMS or its billing agents- any information or documentation needed to determine these benefits or benefits payable for services rendered to me by STFPD#11 EMS now or in the future. I understand that this authorization may be used by this supplier (STFPD#11 EMS) for all services rendered to me now or in the future until such a time that I revoke this authorization in writing to STFPD#11 EMS.
4. **Receipt of STPFD #11- EMS Privacy Practices…**
   I acknowledge that I have been provided with a copy of STFPD#11 EMS **Notice of Privacy Practices** form on this date explaining how or why and to whom medical information concerning myself may be used or shared.
5. **Consent to treatment deemed necessary by STFPD#11 personnel…**
   I hereby consent to treatment deemed necessary by STFPD#11 EMS personnel to me.

_____ _____ _____
Date *Printed Patient Name* *Signature of Patient*

If Patient is unable to sign, Patient must have a representative or an authorized person sign for them:

Reason Patient could not sign: _____

By signing below, I certify that I am one of the following individuals and that I am authorized to sign on this patient's behalf (check one)…

[] Patient's relative or legal guardian- (responsible family member, parent, son, daughter, etc) (42 C.F.R. 424.36 (b) (1))
[] Relative or other person who receives governmental benefits on the patient's behalf (42 C.R.F. 424.36 (b) (2))
[] Relative or other person who arranges this patient's treatment or manages this patient's affairs (42 C.F.R. 424.36 (b) (3))

_____ _____ _____
Date *Printed Name of Representative* *Signature of Representative*

FACILITY SIGNATURE

Complete this section if unable to obtain signature from the patient or patient's authorized representative:

Reason Patient could not sign: _____

By signing below, I certify that this patient cared for was physically or mentally incapable of signing their name on this form at time of transport or arrival at this facility, and that this patient had no one listed in 42 C.R.F. 424.36(b) (1-3) available or willing to sign on the patient's behalf of the beneficiary:

_____ _____
Date *Crew Signature*

Name / address of receiving hospital: _____

The above named person (the patient) was treated and transported by STFPD#11 EMS to this hospital for further care or evaluation on this date.

_____ _____
RN / MD Printed Name & Title *Signature*

Complete this section if the Patient refuses to sign this form, both EMT's are required to sign here:

_____ _____
Driver Signature *Paramedic Signature*

* If the Patient refuses to sign this form, advise the patient he/ she will still be held financially responsible for payment due for services rendered to STFPD #11 EMS and will receive the bill directly via mail. By not signing this form, makes the patient directly responsible.