Over 60 Years of Excellence in Service

Armstrong AMBULANCE SERVICE

Armstrong Ambulance Signature Form

Patient Name: _____ **Transport Date:** _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Armstrong Ambulance Service, Inc. for any services provided to me by Armstrong Ambulance Service, Inc. now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Armstrong Ambulance Service, Inc., 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 Armstrong Ambulance Service, Inc. 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 Armstrong Ambulance Service, Inc. I authorize Armstrong Ambulance Service, Inc. 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 Armstrong Ambulance Service, Inc. 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 Armstrong Ambulance Service, Inc., now, in the past, or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received an Armstrong Ambulance Service, Inc. Notice of Privacy Practices.

-------**SIGNATURE SECTION**:

ONE of the following two 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

_____
Date

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

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.

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.

X_____ _____Representative
Signature Date

_____
Printed Name of Representative

_____
Representative's Address

OP-001206

87 Mystic Street • Arlington, MA 02474 • Telephone 781-648-0612 • FAX 781-648-2662

Acton • Arlington • Boston • Burlington • Cambridge • Hanscom A.F.B. • Medford • Stoneham • Waltham • Wilmington • Woburn