## Billing Authorization & Privacy Acknowledgement

Armstrong AMBULANCE SERVICE

By signing this form, I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Armstrong Ambulance Service 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 Armstrong Ambulance Service, 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 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. I authorize Armstrong Ambulance Service to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Armstrong 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 Armstrong Ambulance Service, now, in the past, or in the future. I also authorize Armstrong Ambulance Service to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have either received, or have been offered and declined, a copy of the Armstrong Ambulance Service, Inc. Notice of Privacy Practices. Also found on our website: www.armstrongambulance.com/forms

**Patient Name** _____ **Run #** _____ **Transport Date** _____/_____/_____

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

**Patient Signature** _____ **Date** _____/_____/_____

### 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 the 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.*

**Representative Signature** _____ **Date** _____/_____/_____

**Printed Name of Representative** _____