

LifeSave Transport Patient Consent Form

acy Practices Acknowledgment: by signing below the			
patient.*A copy of this form is valid as an original*	signer acknowledges that LifeSave p	provided a copy of its Notice of Privacy Practices to the patie	ent or other party with instructions to provide the Notice to
		ON I - PATIENT SIGNATURE ess the patient is physically or mentally incapable of sign	ning
		or, the parent or legal guardian should sign in this section	
rriting. I understand that I am financially responsible for n addition to that which was paid by my insurance. o me and I assign all rights to such payments to LifeS i illing or other relevant information about me to releas neir respective agents or contractors, as may be n	or the services and supplies provided I agree to immediately remit to Lif ave . I authorize LifeSave to appeal _I se such information to LifeSave and i ecessary to determine these or ot	vices provided to me by LifeSave now, in the past, or in the last to me by LifeSave , regardless of my insurance coverage, ar e Save any payments that I receive directly from insurance payment denials or other adverse decisions on my behalf. I its billing agents, the Centers for Medicare and Medicaid ther benefits payable for any services provided to me by on about me from any party, database or other source t	nd in some cases, may be responsible for an amount e or any source whatsoever for the services provided authorize and direct any holder of medical, insurance, Services, and/or any other payers or insurers, and / LifeSave, now, in the past, or in the future. I also
		If the patient signs with an "X" or other mark, a witr	ness should sign below.
X		x	
Patient Signature or Mark	Date	Witness Signature	Date
Patient's Parent/Spouse/Significant Other		Witness Address	
Describe the circumstances that make it impracti	ical for the patient to sign:		
		ORIZED REPRESENTATIVE SIGNATURE the patient is physically or mentally incapable of signing	g.
			
			eptance of financial responsibility for the services
☐ Patient's legal guardian☐ Relative or other person who receives social☐ Relative or other person who arranges for th	security or other governmental bene se patient's treatment or exercises ot	•	
□ Patient's legal guardian □ Relative or other person who receives social □ Relative or other person who arranges for th □ Representative of an agency or institution the	security or other governmental bene se patient's treatment or exercises ot	her responsibility for the patient's affairs	
□ Patient's legal guardian □ Relative or other person who receives social □ Relative or other person who arranges for th □ Representative of an agency or institution the X Representative Signature SECT (2) No author	Date Complete this section only if: (1) trized representative (Section II) with the service of the section only if: (1) trized representative (Section II) with the security of the section only if: (1) trized representative (Section II) with the security of the section only if: (1) trized representative (Section III) with the security of the secu	her responsibility for the patient's affairs hich payment is claimed (i.e., ambulance services) but furnish payment is claimed (i.e., ambulance services) but furnish Printed Name of Representative REW AND RECEIVING FACILITY SIGNAT the patient was physically or mentally incapable of signing as available or willing to sign on behalf of the patient at	hed other care, services, or assistance to the patient TURES ng, and the time of service.
Patient's legal guardian Relative or other person who receives social Relative or other person who arranges for th Representative of an agency or institution the X Representative Signature SECT (2) No author	Date Complete this section only if: (1) trized representative (Section II) waited for the patient to sign:	ther responsibility for the patient's affairs hich payment is claimed (i.e., ambulance services) but furnish payment is claimed (i.e., ambulance services) but furnish Printed Name of Representative REW AND RECEIVING FACILITY SIGNAT the patient was physically or mentally incapable of signing as available or willing to sign on behalf of the patient at	hed other care, services, or assistance to the patient FURES ng, and the time of service.
Patient's legal guardian Relative or other person who receives social Relative or other person who arranges for th Representative of an agency or institution the Representative Signature SECT (2) No author Cescribe the circumstances that make it impractions Cescribe the circumstances Cescribe the circum	security or other governmental bene be patient's treatment or exercises of the patient or exercises of the	ther responsibility for the patient's affairs hich payment is claimed (i.e., ambulance services) but furnish payment is claimed (i.e., ambulance services) but furnish Printed Name of Representative REW AND RECEIVING FACILITY SIGNAT the patient was physically or mentally incapable of signing as available or willing to sign on behalf of the patient at Time Time	hed other care, services, or assistance to the patient FURES ng, and the time of service.
Patient's legal guardian Relative or other person who receives social Relative or other person who arranges for th Representative of an agency or institution the SECT (2) No author Describe the circumstances that make it impraction Name and Location of Receiving Facility: A signature below authorizes submission of a clair A. Ambulance Crew Member Statement (mus My signature below indicates that, at the ti	Date CON III - AMBULANCE C Complete this section only if: (1) trized representative (Section II) will be to Medicare, Medicaid, or any of the completed by crew member ime of service, the patient's behalf	her responsibility for the patient's affairs hich payment is claimed (i.e., ambulance services) but furnish payment is claimed (i.e., ambulance services) but furnish payment is claimed (i.e., ambulance services) but furnish printed Name of Representative REW AND RECEIVING FACILITY SIGNAT the patient was physically or mentally incapable of signing as available or willing to sign on behalf of the patient at the patient at the payer for any services provided to the patient by Leather payer for any services payer payer payer for any services payer	FURES ng, and the time of service. ifeSave. of the authorized representatives listed in
Patient's legal guardian Relative or other person who receives social Relative or other person who arranges for th Representative of an agency or institution the Representative Signature SECT (2) No author Describe the circumstances that make it impractive Name and Location of Receiving Facility: A signature below authorizes submission of a clair My signature below indicates that, at the tice Section II of this form were available or will	Date CON III - AMBULANCE C Complete this section only if: (1) trized representative (Section II) will be to Medicare, Medicaid, or any of the completed by crew member ime of service, the patient's behalf	ther responsibility for the patient's affairs hich payment is claimed (i.e., ambulance services) but furnish payment is claimed for the patient was physically or mentally incapable of signinas available or willing to sign on behalf of the patient at the payment of the patient by the payment of the payment is claimed to the patient by the payment of the payment is claimed to the patient by the payment of the payment is claimed to the patient by the payment of the payment is claimed to the patient by the payment is claimed to	TURES Ing, and the time of service. IfeSave. Ingoing the authorized representatives listed in assibility for the services rendered.
Relative or other person who receives social Relative or other person who arranges for the Representative of an agency or institution the Representative Signature SECT (2) No author Describe the circumstances that make it impractive Name and Location of Receiving Facility: A signature below authorizes submission of a clair A. Ambulance Crew Member Statement (mus My signature below indicates that, at the times Section II of this form were available or will the Signature of Crewmember Signature of Crewmember B. Receiving Facility Representative Signature	Date CON III - AMBULANCE C Complete this section only if: (1) trized representative (Section II) will be completed by crew member ime of service, the patient was phyling to sign on the patient's behalf be completed by this facility on the date and see eed by this facility on the date and see eed by this facility on the date and see eed by this facility on the date and see eed by this facility on the date and see eed to the patient's behalf and see eed to the patient of the patient of the patient's behalf on the patient's be	Printed Name of Representative Printed Name of Representative REW AND RECEIVING FACILITY SIGNAT the patient was physically or mentally incapable of signing as available or willing to sign on behalf of the patient at Time other payer for any services provided to the patient by Least time of transport) spically or mentally incapable of signing, and that none of the signing and that none of the signing are considered to the patient by Least time of transport) spically or mentally incapable of signing, and that none of the signing and that none of the signing are considered to the patient by Least time of transport)	FURES ng, and the time of service. ifeSave. of the authorized representatives listed in sibility for the services rendered. ber