KCEMSS Refusal/AMA Signature Form

☑ INSURANCE BILLING AUTHORIZATION FORM FOR EMT/PARAMEDIC ON SCENE ASSESMENT AND/OR AMBULANCE SERVICE

This form authorizes Kootenai County EMS to bill Medicare and/or any other insurance company or government health benefit program for the ambulance and/or paramedic/EMT services provided to you or your dependents. If this form is not signed, you are responsible for paying the entire balance of your account "I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to KCEMSS for any services provided to me by KCEMSS now or in the future. I understand that I am financially responsible for the services provided to me by KCEMSS, 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 KCEMSS 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 KCEMSS. I authorize KCEMSS to appeal payment denials or other adverse decisions on my behalf without further authorization."

"I authorize and direct any holder of medical information or documentation about me to release such information to KCEMSS and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by KCEMSS, now or in the future. A copy of this form is as valid as an original."

☐ PATIENT CONSENT FOR RELEASE NON- EMT/PARAMEDIC TRANSPORT NON-INJURY OR MINOR INJURY

I understand that a preliminary field evaluation has not revealed any condition sufficiently serious to require transportation to the hospital by EMTs/Paramedics. I agree with this assessment. I also understand that, while I still have the option of being transported to the hospital by EMTs/Paramedics, I prefer to make my own transportation arrangements for further evaluation. If my present condition worsens, I have been advised to seek prompt medical evaluation, which may include requesting EMTs/Paramedics respond again by dialing 911. This is to certify that I release Kootenai County EMS and its employees and agents from any liability for any claim arising from, or associated with, my injuries or medical condition.

☐ PRE-HOSPITAL PATIENT RELEASE AGAINST MEDICAL ADVICE (AMA) **Refusal of Medical Treatment and Transportation**

This is to certify that I release Kootenai County EMS and its employees and agents, the hospital or facility and its staff, and any treating physicians, from liability for any claim arising from, or associated with, my injuries or medical condition; and I refuse further treatment and medical transportation to the hospital, even though I am informed and I am aware that my injuries or medical condition may be serious and may require further treatment.

☐ TRANSPORT DESTINATION AGAINST MEDICAL ADVICE (DESTINATION AMA) **Refusal of Transport to Nearest Facility**

This is to certify that I release Kootenai County EMS and its employees and agents, the hospital or facility and its staff, and any treating physicians, from liability for any claim arising from, or associated with, my injuries or medical condition; and I refuse transport to the closest hospital that is capable of treatment of my illness or injury. I also understand that KCEMSS is under the medical direction of Kootenai County physicians and will be transporting out of their medical direction. I am informed and I am aware that my injuries or medical condition may be serious and may require immediate treatment. I acknowledge that I have read and understand the terms of this release, and I have signed it voluntarily. I agree that this release shall be binding on my relatives, heirs, legal representatives and assigns.

I acknowledge that I have read and understand the terms of this release, and I have signed it voluntarily. I agree that this release shall be binding on my relatives, heirs, legal representatives and assigns. I understand that I may be billed for services, procedures and/or assessments that were provided to me on scene.

X _____ _____

Patient Signature Date

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 is a minor – Parent to sign below
☐ Relative or other person who receives government benefits on behalf of patient
☐ Patient's Health Care Power of Attorney
☐ Relative or other person who arranges treatment or handles the patient's affairs

I am signing on behalf of the patient and release KCEMSS of liability

X _____ _____ _____

Representative Signature Date Printed Name of Representative

_____

Representative's Address