← **\*Add Hospital MRN Imprint in This Corner\*** NFIRS INCIDENT # 21-

SIREN CALL # W21-

**WILLISTON FIRE DEPARTMENT**

**PATIENT BILLING AUTHORIZATION**

Name of EMT Completing This Form: Date of Service / / 2021

Patient Date of Birth / / **Loaded Miles #:**

Patient Name:

(Last) (First) (Middle)

MAILING Address:

( ) Williston, VT 05495 -OR- City State Zip

Home Phone Cell Phone

INCIDENT Address: ( ) Same -OR-

( ) Williston, VT 05495 -OR- City State Zip

Workman’s Comp Claim: □ Yes □ No (If yes, please complete line below)

Employer: Telephone #:

**Privacy Practices Acknowledgment:** By signing below, the signer acknowledges that the **Town of Williston Fire Department (**hereafter **“**WFD**”)** provided a copy of its *Notice of Privacy Practices & Lifetime Authorizations* to the patient.

**\*A copy of this form is valid as an original\***

**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, THE PARENT OR LEGAL GUARDIAN SHOULD SIGN IN THIS SECTION.**

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by WFD 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 provided to me by WFD, regardless of my insurance coverage, and in some cases, I may be responsible for any remaining balance after my insurance has paid. I agree to immediately remit to WFD 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 WFD. I authorize WFD 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 WFD and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors 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 WFD, now, in the past, or in the future. I understand and agree to the following terms:

* All invoices are due upon receipt, with the full balance due within 90 days of the date of service.
* Any balance due past 90 days of the date of service will be submitted to an outside agency for collection of a debt and will be assessed reasonable collection and attorney fees as allowed by state and federal law.
* For assistance paying my bill, I can contact the WFD at (802) 878-5622 for information regarding their Transport Fee Waiver program.
* To schedule a payment arrangement on any balance due, I can contact the WFD billing agent at (802) 476-0254 x4. Accounts that adhere to a timely payment arrangement will not be subject to additional fees. Accounts that do not adhere to the payment arrangement will become subject to the terms and fees listed above.

***If the patient signs with an “X” or other mark, a witness should sign below.***

**For Known or Suspected COVID-19 Patient Only**

 **CHECK HERE** if patient gave verbal consent for ambulance crew to sign

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  
Ambulance Crew Member Signature & Printed Name Date  
(Crew member should sign own name and not patient’s name)

X

Patient Signature or Mark Date

X

Witness Signature Date

**PATIENT BILLING AUTHORIZATION Page 2**

**Patient Name: Date of Service:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/2021**

**Privacy Practices Acknowledgment:** By signing below, the signer acknowledges that the **Town of Williston Fire Department (**hereafter **“**WFD**”)** provided a copy of its *Notice of Privacy Practices & Lifetime Authorizations* to the patient, or to the signer or another party with instructions to provide the Notice to the patient.

**\*A copy of this form is valid as an original\***

**SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE**

***Complete this section only if the patient is physically or mentally incapable of signing.***

On the line below, explain the circumstances that make it impractical for the patient to sign:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by WFD now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized representatives listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals listed below. Please check one:

🞎 Adult patient’s legal guardian. *~ See Section I for minors ~*

🞎 Spouse, relative or other person who arranges for the patient’s treatment or who exercises other responsibility for the patient’s affairs.

🞎 Relative or other person who receives social security or other governmental benefits on behalf of the patient.

🞎 Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient.

X

Representative Signature Date

Printed Name and Address of Representative

**SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES**

***Complete both sections A and B only if: (1) the patient was physically or mentally incapable of signing, and***

***(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.***

**A.** **Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)**

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by WFD**. My signature is not an acceptance of financial responsibility for the services rendered.**

On the line below, explain the circumstances that make it impractical for the patient to sign:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Location of Receiving Facility: 🞎 University of Vermont Medical Center, 111 Colchester Avenue, Burlington, VT 05401

🞎

Time of Arrival at Receiving Facility:

X

Signature of Ambulance Crew Member Date

Printed Name and Title of Crew Member Call Tag Number

1. **Receiving Facility Representative Signature**

The patient named on this form was received by this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X

Signature of Receiving Facility Representative Date

Printed Name and Title of Receiving Facility Representative