

KINROSS EMS

CONSENT TO BILL INSURANCE COMPANY FOR MEDICAL TREATMENT

I, _____
(patient)

I authorize the release of any medical information necessary to process claims for service rendered by Kinross EMS. This authorization includes any necessary medical records information either to be released from the transferring or receiving medical facilities to Kinross EMS for this date of service. I understand that this information is to be used for the purpose of insurance claim submission only. I transfer and assign all right, title and interest in any such payments for such services to Kinross EMS. I give Kinross EMS permission to bill my insurance company for services rendered on my behalf. I further recognize that I am personally responsible for the ambulance service fees not covered by my insurance.

(Patient or representative signature)

(Date)

In the event family or other responsible parties are not present and the patient is unable to sign this form, my signature below indicates my witness to the above being explained to the patient.

(Hospital representative or ambulance crew signature)

(Date)

MEDICARE NON-EMERGENT SERVICES:

I have been notified by Kinross EMS that in my case Medicare may deny payment for services that they deem not medically necessary. If Medicare denies payment, I agree to be personally and fully responsible for the payment of this Kinross EMS service.

(Patient or representative signature)

(Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kinross EMS's Notice of Privacy Practices describes the specific meaning of "treatment", "payment", and "health care operations" and how Kinross EMS uses and discloses my health information to carry out these functions. I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Date

Signature of Patient or Representative

Relationship, if not Patient

Reason acknowledgement could not be obtained: _____

