PRIDESTAR
TRINITY EMS

Patient Name:_____Transport Date_____ Run #_____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to PrideStar Ambulance Service for any services provided to me by PrideStar Ambulance Service now, in the past, or in the future. I understand that I am financially responsible for the services provided to me by PrideStar 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 PrideStar Ambulance Service any payment 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 PrideStar Ambulance Service. I authorize PrideStar Ambulance Service to appeal payment denials or other adverse decisions on my behalf without further authorizations. I authorize and direct any holder of medical information or documentation about me to release such information to PrideStar Ambulance Service 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 PrideStar Ambulance Service, now or in the future. A copy of this form is as valid as an original. Privacy Practices Acknowledgment: By signing below, I acknowledge that I have received PrideStar Ambulance Service's Notice of Privacy Practices

SIGNATURE SECTION

ONE of the following three sections MUST be completed

SECTION I – PATIENT SIGNATURE	**SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE**
This section is for emergencies or non-emergencies. The patient must sign here unless the patient is physically or mentally incapable of signing **X**_____ Patient Signature or Mark If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. **X**_____ **Witness Signature** **X**_____ **Witness Printed Name**	This section is for emergencies or non-emergencies. Complete this section **ONLY** if 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: ○ Patient's legal guardian ○ Patient's Health Care Power of Attorney ○ Relative or other person who receives government benefits on behalf of the patient ○ Relatives or other persons who arrange treatment or handle patient 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. **X**_____ _____ Representative Signature Printed name