ASHLAND RESCUE SERVICES REFUSAL FORM

Date:_____ Dispatch Reason_____ Run#_____

Dispatch Address_____ (Street, City, State)

Patient Name_____ DOB_____

Patient Address_____ SSN_____

1. I hereby refuse transportation by the Ashland Rescue Service
2. The nature and consequences of refusing treatment and/or transportation have been explained to me. I understand it may involve further illness or injury that may result in health complications and may be a threat to life. I understand if I change my mind I may call 911 for emergency services.
3. The risk, benefits, and options of treatment and transportation have been explained to me.
4. I hereby freely and voluntarily refuse to give my consent to treatment and/or transportation.
5. I understand my insurance company may be billed for ALS services provided.

Mental assessment by AES Personnel. Patient was found to be:

ALERT	YES	NO	**PULSE**	_____	**O2**_____
COHERENT	YES	NO	**BP**	_____	**BS**_____
ARTICULATE	YES	NO	**RESPIRATIONS**	_____	**PUPILS**_____
STROKE SCALE	_____		**GSC**	_____	

Medications:_____

Allergies:_____

Comments:_____

INSURANCE INFORMATION: (only collect if ALS expendible equipment was used to treat patient)

Insurance Carrier/Company:_____

Policy#_____ Is this "SELF PAY"?_____

Does the Patient have Medicare? YES NO

Does the Patient have Medicaid? YES NO

I request that payment of authorized Medicare, Medicaid, or other Insurance benefits be made on my behalf to Ashland Rescue Services for any services provided to me by Ashland Rescue Service now or in the future. I agree to immediately remit to Ashland Rescue Service any payments I receive directly from any source whatsoever for the services provided to me no or in the future. I assign all rights and/or benefits to such payments to Ashland Rescue Service for comensation of services provided to me now or in the future.

I authorize and direct any holder of medical information or documentation about me to release such information to the Centers of Medicare and Medicaid Services and its carriers and agents, and/or Ashland Rescue Services and its billing agents, and/or any other payers or insurers, as as may be necessary to determine these benefits or other payable for services provided to me by Ashland Rescue Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:_____ (Patient Initials)

PATIENT'S SIGNATURE:_____ DATE:_____

WITNESS:_____ RELATIONSHIP TO PATIENT_____

All AES PERSONNEL AT SCENE:_____

LIST ALL MEMBERS

EMS SIGNATURE FORM v2.1 Revised 1/2020

For Ashland Emergency Service

Transport Date_____

Patient Name_____

Loaded Odometer Start_____

Loaded Odometer End_____

Loaded Miles_____

Author of Medical Record: Signature Required

Assessment performed by:_____**EMT**

_____ALS Certified _____BLS Certified

Printed Name_____**EMT**

Name of ALS intercepting service(if applicable)_____

Point of Pickup Name/Address/City/State:_____ Zip_____

Patient Home Skilled Nursing Facility Hosptial Nursing Home Other

Destination Name/Address/City/State:_____Zip_____

_____Patient Home _____Skilled Nursing Facility ____Hosptial ____Nursing Home ____Other

If transporting more than one Patient Name(s)_____

If Hospital to Hospital Transport, provide reason Specialty

A copy of this form is as valid as an originial

PRIVACY AWARENESS ACKNOWLEDGEMENT ☐ REFUSED PRIVACY POLICY

By signing below, the signer acknowledges that Ashland Emergency Service provided a copy of its Notice of Practice Practices to the Patient or other party with instructions to provide the Notice to the patient.

Section I: Patient Signature

Release of Payment/Release of Medical/Billing Information:

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by Ashland Emergency Service 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 and supplies provided to me by Ashland Emergency 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 Ashland Emergency Service any payments that I receive directly from Insurance or any other source whatsoever for the services provided to me and I assign all rights to such payments to Ashland Emergency Service. I authorize Ashland Emergency Service 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 Ashland Emergency Service and its billing agents, the Centers for Medicare and Medicaid Service, 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 Ashland Emergency Service, now, in the past or in the future. This is a lifetime authorization for any services provided to me by Ashland Emergency Service. I also authorize Ashland Emergency Service to obtain medical, insurance, billing and other relevant information about me from any party, database, or other source that maintains such information.

***Patient's Signature:**_____**Date:**_____

If the Patient is a minor, the parent or legal guardian should sign. If signed with an "X" or other mark, a witness should sign below.

Witness Signature:_____**Date:**_____

Section II: Authorized Representative Signature

The patient is physically or mentally incapable of signing because of the following reason(s):

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 Ashland Emergency Service now or in the past(or in the future, where permitted). By signing, I acknowledge that I am one of the authorized signer listed:

___Patient's Legal Guardian ___Spouse ___POA ___Originating Facility ___Person who receives SSN or other gov't benefits on behalf of patient

___Rep of agency, not furnishing ambulance service, but furnished other care, services, or assistance to the patient

***My signature is not an acceptance of financial responsibility for services rendered.**

Representative Signature:_____Date:_____

Section III: Ambulance Crew And Reveiving Facility Signature

For Emergency Transports Only:

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 for payment to Medicare, Medicaid or any other payor for any services provided to the patient by Ashland Emergency Service ***My signature is not acceptance of financial responsibility for services rendered.**

Name and Location of the Receiving Facility_____Time at Receiving Facility_____

Reason patient named above was unable to sign:_____

Crewmember Signature:_____**Printed Name/Title**_____**Date**_____

Receiving Facility Representative Signature: The patient named on this form was received by this facility at the date and time indicated above. 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 provided to the patient by Ashland Emergency Service ***My signature is not acceptance of financial responsibility for services rendered.**

Signature of Receiving Facility Representative_____**Date**_____

Printed Name and Title of Receiving Facility Representative_____