

Black Forest Fire Ambulance
CONSENT TO TREAT AND BILLING AUTHORIZATION

With this I consent (GIVE MY PERMISSION) to medical treatment and transportation by; BLACK FOREST FIRE & RESCUE to the medical facility listed below. I understand that I am financially responsible to BLACK FOREST FIRE & RESCUE for any and all payments/charges incurred as a result of this treatment and transportation.

Additionally, I request that payment of authorized insurance benefits be made on my behalf to BLACK FOREST FIRE & RESCUE for any ambulance or medical services provided to me by BLACK FOREST FIRE & RESCUE DEPARTMENT.

Finally, I authorize any holder of medical information or documentation about me to release to the Health Care Finance Administration, its agents and carrier, as well as to BLACK FOREST FIRE & RESCUE; any information or documentation needed to determine these benefits payable as a related to services provided to me by BLACK FOREST FIRE & RESCUE now or any time in the future.

Patient Name: _____ Phone #: _____

Date of Birth: _____ Social Security No. _____

Patient Signature: _____ Date: ___/___/___

or

Responsible Person: _____

Address: _____

Relationship to Patient: _____ **Phone #:** _____

Date of Birth: _____ Social Security No. _____

Signature: _____ Date: ___/___/___

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of *Black Forest Fire Ambulance's* Notice of Privacy Practices on this date.

Date

Signature

PRINT NAME OF PATIENT IF NOT LISTED

ABOVE

IF PATIENT IS UNABLE TO SIGN EITHER FORM, STATE REASON:

WITNESSES:

NAME: _____ **SIGNATURE:** _____

NAME: _____ **SIGNATURE:** _____