Patient Name: ______________________________ **Transport Date:** ____________________

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **[HOPS Ambulance Association (HOPS)]** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice 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 to Medicare, Medicaid, or any other payer for any services provided to me by **[HOPS]** 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 **[HOPS]**, 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 **[HOPS]** 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 **[HOPS]**. I authorize **[HOPS]** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **[HOPS]** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers 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 ABC, now, in the past, or in the future. I also authorize **[HOPS]** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

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

X______________________ ________ X______________________ ________
Patient Signature or Mark Date Witness Signature Date

Witness Address

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

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

Describe 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 to Medicare, Medicaid, or any other payer for any services provided to the patient by **[HOPS]** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ 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 of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **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.

Describe the circumstances that make it impractical for the patient to sign: ______________________

Name and Location of Receiving Facility: ______________________ Time: __________

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **[HOPS]**.

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

X______________________ ________ ______________________
Signature of Crewmember Date Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X______________________ ________ ______________________
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

H.O.P.S. Ambulance Association

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

H.O.P.S. Ambulance Association is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information, or PHI, and to provide you with a notice of our legal duties and privacies with respect to your PHI. H.O.P.S. Ambulance Association is also required to abide by the terms of the version of this Notice currently in effect. **Uses and Disclosures of PHI:** H.O.P.S. Ambulance Association may use PHI for the purposes of treatment, payment, and health care operations, in most cases, without your written permission. Examples of our use of your PHI are the following: **For Treatment:** This includes such things as obtaining verbal and written information about your medical condition and treatment from you, as well as others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other healthcare providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center. **For Payment:** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations, and collecting outstanding accounts. **For Health Care Operations:** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions. **Reminders for Scheduled Transports and Information on Other Services:** We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provider information about other services we provide. **Use and Disclosure of PHI Without Your Authorization:** H.O.P.S. Ambulance Association is permitted to use PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including: *For the treatment, payment or health care operations activities of another health care provider who treats you. To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give such a disclosure and you do not raise an objection, and in certain other circumstances where we are and believe the disclosure is in your best interests. To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence). For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process. For law enforcement activities in limited situations, such as when responding to a warrant. For military, national defense and security and other special government functions. To avert a serious threat to the health and safety of a person or the public at large. For workers' compensation purposes, and in compliance with workers compensation laws. To corners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation. For research projects, but this will be subject to strict oversight and approvals. We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.* Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient, you have a number of rights with respect to your PHI, including: *The right to access copy or inspect your PHI. This means you may inspects and copy most of the medical information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer. The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we have about you, you should contact our privacy officer. The right to request an accounting. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used of disclosed for purposes of treatment, payment, or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer. The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. H.O.P.S. Ambulance Association is not required to agree to any restrictions you request, but any restrictions agreed to by H.O.P.S. Ambulance Association in writing are binding on H.O.P.S. Ambulance Association. Internet, electronic mail, and the right to Obtain Copy of Paper Notice on Request. If we maintain a website, we will prominently post a copy of this Notice on our website. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice. Revisions to the Notice: H.O.P.S. Ambulance Association reserves the right to change the terms of this Notice at any time and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted on our website if we maintain one. You can get a copy of the latest version of the notice by contacting our privacy officer. Your legal rights and complaints. You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints, you may direct all inquiries to our privacy officer.*

Privacy Officer Contact Information:
H.O.P.S. Ambulance Association
6185 Herrickville Rd Wyalusing PA 18853
Station Phone: (570)744-1700