Care Ambulance Service Inc.
1517 W BRADEN COURT, ORANGE, CA, 92868
(714) 288-3834

Responsible Party

Dear Customer, In order for Care Ambulance to bill your insurance carrier we must have your Signature authorizing the release of information to your carrier on file. **It is very important that you sign this form and send to the address above, failure to do so will result in holding you, the customer, responsible for the entire Amount Due listed below.** If you have additional questions, please contact us.

Name: _____ **Transport Date:** _____

Address:_____ **Amount Due:**_____

City\State:_____ **Patient Account#:**_____

Patient Signature Authorization: (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 request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Care Ambulance Service Inc. for any services provided to me by Care Ambulance Service Inc. now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Care Ambulance Service Inc., 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 Care Ambulance Service Inc. 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 Care Ambulance Service Inc.. I authorize Care Ambulance Service Inc. 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 Care Ambulance Service Inc. 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 Care Ambulance Service Inc., now, in the past, or in the future. A copy of this form is as valid as an original.
I agree, in order for you to service my account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, or telephone numbers found from other sources, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using prerecorded or artificial voice messages and/or use of an automatic telephone dialing system or other dialing device, as applicable.

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

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.

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

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

If signing below this must be filled out:

Reason the patient is physically or mentally incapable of signing:_____

X_____ _____
Representative Signature | Date

X_____
Printed Name of Representative and Representative Address

X_____