PORT CITY AMBULANCE

Signature Authorization

Patient Name: _____ **Service Date:** _____ **Run #**_____

This is acknowledgement that I accept treatment and transport by Priority Ambulance, LLC ("Port City Ambulance") (or an affiliate or subsidiary). I hereby acknowledge that I have received a copy of or have been provided a link [https://priorityambulance.com/privacy-policy/] to the Notice of Privacy Practices (NPP) for Priority Ambulance and its affiliates. I understand that this notice describes how my health information may be used and shared, and that I have the right to review it. I hereby assign and convey directly to Provider as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services provided by the Provider now, in the future, or in the past, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Provider to release all medical information (either directly or through a third-party billing company) necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Provider all Plan documents, summary benefit description , insurance policy, and/or settlement information upon written request from Provider or its attorneys to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Provider any legal or administrative claim or cause of action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred because of the services I receive from Provider (including any right to pursue those legal or administrative claims or cause of action).

This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to Provider all my rights to claim (or place a lien on) the medical benefits related to the services provided by Provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or cause of action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, and applicable federal and state laws. A photocopy or electronic version of this assignment is to be considered valid, the same as if it were the original.

WIRELESS COMMUNICATION POLICY AND CONSENT: By providing Priority Ambulance, LLC ("Port City Ambulance") with a phone number and/or email address you, or anyone authorized to act on your behalf, are providing express consent authorizing the Provider, as well as its agents, subsidiaries, affiliates, officers, employees, partner, successors in interest, and any companies, acting on its behalf, to contact you at any phone number or email address you provide or have provided to the Provider at any time with information related to your account. By providing the Provider with any phone number or email address, you are confirming you are the owner of or are authorized to use the provided phone number or email address. You also confirm that you will notify the Provider immediately if you no longer own or are no longer authorized to use any phone number or email address you provide to the Provider. You permit the Provider to contact you via live operator, automatic telephone dialing systems, prerecorded and artificial voice messages, text messages (SMS or MMS), or email. Phone numbers and email addresses you authorized the Provider to use to contact you include any that you provide to the Provider, any that you contact the Provider from, any that are provided to the Provider by someone acting on your behalf, and any that the Provider locates from other lawful sources. You understand that you are solely responsible for payment of any messages rates and data charges associated with communications you receive from or send to the Provider. You acknowledge that you have read fully, understand, and will comply with this Wireless Communication Policy and Consent.

Section 1: Patient Signature

Patient must sign here unless mentally or physically incapable. If the patient signs with an "X" or other mark, a witness should sign below.

X_____ _____

Patient Signature or Mark — Date

X_____ _____

Witness Signature — Witness Printed Name — Date

Section 2: Authorized Representative Signature

Complete ONLY if the patient is physically/mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

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

- ☐ Patient's legal guardian
- ☐ Patient's Health Care Power of Attorney
- ☐ Relative or other person who receives social security or other government benefits on behalf of the patient.
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibilities for the patient's affairs.
- ☐ Representative of an agency/institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but 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 services rendered.

X_____ _____

Representative Signature — Representative Printed Name — Date

Section 3: Ambulance Crew & Receiving Facility Signatures

Complete this section only if the patient was mentally/physically incapable of AND no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service. Ambulance Crew Member Statement must be completed by member at the 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 behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason PT incapable of signing: _____

Name / Location of Receiving Facility: _____

Signature / Printed Name of Crew Member X_____ Date _____ **Receiving Facility Representative Signature: The patient named on this form was received by this facility at the date indicated. My signature is not an acceptance of financial responsibility for the services rendered to this patient. I have been given report by the ambulance crew, including the patient's current condition. I have had all my questions answered and accept care of this patient.**

X_____ _____ _____

Signature of Receiving Facility Representative — Date — Printed Name and Title of Receiving Facility Representative