

INSURANCE / PATIENT BILLING INFORMATION

LAST NAME:	FIRST:	MI:	AGE:	DOB:	SEX:
STREET ADDRESS:		CITY / TOWN:	STATE:	ZIP CODE:	
HOME TELEPHONE #:					
MEDICARE ID #:			MEDICAID / WELFARE ID #:		
INSURANCE COMPANY NAME:			POLICY NUMBER:		
STREET ADDRESS:		CITY / TOWN:	STATE:	ZIP CODE:	
INSURANCE COMPANY NAME (MVA / WORKERS' COMPENSATION):			POLICY NUMBER:		
STREET ADDRESS:		CITY / TOWN:	STATE:	ZIP CODE:	
HOSPITAL MEDICAL RECORD NUMBER:					

PATIENT AUTHORIZATION

I authorize the release of my medical records or other information to the Social Security Administration, the Centers for Medicare and Medicaid Services (formerly HCFA), its intermediaries or carriers, the state Department of Social Services / Welfare, other insurance carriers and the [NAME OF SERVICE] for the processing of this claim, as well as any related or future claim. I agree that payment should be made directly to [NAME OF SERVICE]. I agree to pay this charge within 30 days of service. I promise to pay any charges not covered by my insurance carrier as well as any collection costs and / or attorney's fees as allowed by law.

Signature of patient or responsible party

Date

Patient unable to sign; REASON: _____

Patient accepted by hospital representative: _____ RN MD / DO

PATIENT REFUSAL

This is to certify that I,

am refusing the services (treatment and/or transport) offered by the ambulance and its attendant(s). I acknowledge that I have been informed of the risk involved and hereby release the ambulance attendant(s), the physician consultant, and the consulting hospital from all responsibility for any ill effects that result from this action.

Signed by Patient: _____

Witness: _____