Life Link III Signature Form (18 Years and Older)

Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Life Link III 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 & PARENT OF MINOR CHILD

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is 18 or older, the parent or legal guardian should sign section II.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Life Link III 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 Life Link III, 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 Life Link III 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 Life Link III. I authorize Life Link III 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 Life Link III 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 Life Link III, now, in the past, or in the future. I also authorize Life Link III 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

X_____ _____
Printed Name of Signer | Witness Address

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Family members (of adult patients) or sending hospital staff 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 Life Link III 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 of patient 18 years or older
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who is arranging 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 & Relationship to Patient

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete Crew section 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 Life Link III.

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

Signature Form Instructions for Adults (18 Years & Older)

Section I

The only signature that should be captured in this section is the patient's. Please print the first and last name of the patient on the line below their signature. If the patient is unable to sign but can make an X, then a witness signature and address (if a Life Link III employee is the witness, use the company address) must be captured to the right of the patient signature line.

Section II

If the patient is unable to sign on their own behalf (mentally or physically incapable), then capture a signature from a family member (spouse, adult child, grandparent of adult patient) or a staff person from the sending facility (health care provider) in this section.

Indicate the reason the patient was unable to sign the form themselves on the first line in this section (ie. Intubated, narcotics given, trauma to arms, altered mental status (if the current mental status is not their normal)).

Check one of the four boxes in this section as well indicating the relationship of the signer to the patient. Most often you will be checking either the first box if the patient's legal guardian (of patient 18 years or older) is signing; the third box if another family member is signing for the patient or the fourth box if you are getting a signature from a staff member at the sending facility.

Legibly print the full first and last name of the signer along with their relationship to the patient.

Section III

If the patient is not able to sign and there is no family member or sending facility staff member available/willing to sign, then Section III must be completed. On the line that indicates "describe the circumstances that make it impractical for the patient to sign" indicate as in section II why the patient could not sign the form. Fill in the name of the receiving facility and the time you arrived there and then one of the Life Link III crew members needs to sign option "A" Ambulance Crew Member Statement and then a representative from the receiving facility needs to sign option "B". In both cases, the name and title/certification of the person signing must be indicated on the line to the right of the signature.

For All Transports

All transports require a receiving facility signature. This is proof to the insurance payors that the patient was actually transported somewhere. Instead of creating a second signature form to capture this signature, please have the receiving facility staff person sign option "B" in Section III on all transports (regardless if you are capturing a parent/guardian signature in Section I).

LISBARR

L	Listen
I	Introduce
S	Situation
B	Background
A	Assessment
R	Response
R	Recommendation