

**LANE RURAL FIRE/RESCUE
TREATMENT CONSENT & LIFETIME SIGNATURE FORM**

Patient Name: _____ **D.O.S.:** _____ **Run Number: LR** _____

LANE RURAL FIRE/RESCUE ambulance personnel have permission to treat me. I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to **LANE RURAL FIRE/RESCUE ("LRFR")** for any services provided to me by **LRFR** now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by **LRFR**, 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 **LRFR** 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 **LRFR**. I authorize **LRFR** 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 **LRFR** 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 **LRFR**, now, in the past, or in the future. **A copy of this form is as valid as an original.**

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received LRFR's Notice of Privacy Practices.

SIGNATURE SECTION:

ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____ Date _____
Patient Signature or Mark

If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

X _____ Date _____
Witness Signature

Witness Printed Name

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or 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 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.

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.

X _____ Date _____ Printed Name of Representative
Representative Signature

Representative's Address

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.

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 named above 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.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ Date _____ Printed Name of Crewmember
Signature of Crewmember

B. Receiving Facility Representative Signature

*The patient named on this form was received by this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.***

X _____ Date _____ Printed Name and Title of Receiving Facility Representative
Signature of Receiving Facility Representative

**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.**

Lane Rural Fire/Rescue 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 privacy practices with respect to your PHI. Lane Rural Fire/Rescue is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: Lane Rural Fire/Rescue 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:

For treatment: This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care 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 distribute information about other services we provide.

Use and disclosure of PHI without your authorization: Lane Rural Fire/Rescue 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 treatment, payment for services or health care operations activities of another health care provider who treats you;

For health care and legal compliance activities;

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 you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement 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 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 coroners, 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. You may revoke your 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 inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this 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 forms available 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 also 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 amend the medical information 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 or 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. Lane Rural Fire/Rescue is not required to agree to any restrictions you request, but any restrictions agreed to by Lane Rural Fire/Rescue in writing are binding on Lane Rural Fire/Rescue.

Internet, Electronic Mail, and the right to obtain copy of paper notice on request. If we maintain a web site, we will prominently post a copy of this Notice on our site. If you allow us we will forward you this Notice by electronic mail instead of paper and you may always request a paper copy of the Notice.

Revisions to the Notice: Lane Rural Fire/Rescue 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 to our web site, if we maintain one. You can get a copy of the latest version of this 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: Emergency Medical Services Office 29999 Hallett St. Eugene, OR. 97402 (541) 688-1770 Fax (541) 688-3937 www.lfrf.org
Effective date of this Notice: April 14, 2003, information updated: February 2006