Financial Responsibility, Benefit Assignment, Information Release

Insurance benefits: I give City of Pullman permission to bill my insurance or other entity providing benefits to me for the ambulance services I received. My insurance has permission to pay City of Pullman directly for any services billed. If I or any family member should receive payment for ambulance services provided by the Pullman Fire Department, I shall immediately forward such payment to City of Pullman. I understand that I will be billed and am responsible for payment for any services.

City of Pullman Fire Department will submit a claim on behalf of the patient to the patient's insurance company. It is the responsibility of the patient to provide City of Pullman Fire Department with accurate and current insurance information. Insurance claim filing is done as a courtesy. City of Pullman has the right to refuse to bill an insurance company after two attempts. If the claim is denied after the second attempt for insufficient or inaccurate information, the patient is required to pay their account balance in full immediately. It will then become the patient's responsibility to submit a claim for reimbursement and resolve the matter with their insurance company for the ambulance service.

Medical personnel, as well as staff, at Pullman Fire Department, City of Pullman Finance Department and Information Systems have access to these records in the aspect that pertains to their jobs. City of Pullman staff contacts patients, patients' families, or other healthcare facilities to obtain further information when not provided or provided incorrectly to complete the billing process. This information is used to bill insurance or collect on unpaid accounts. Copies of medical records are often requested from insurance companies to process a claim and these are sent in a timely manner. I acknowledge that I have been offered a copy of City of Pullman Ambulance Privacy Practices. Unless otherwise revoked in writing, this waiver will be used for any services provided to you by City of Pullman.

Blue OR Black Ink ONLY

Patient Signature: _____Date_____

(A legal patient signature is that of an individual 18 years and older)

OR an Authorized Representative Signature: _____ Date: _____

(Legal Guardian, Immediate Family Relative)

Relationship to Patient: _____

Printed Name: _____Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ SSN: _____-_____-_____ DOB: ____/___/_____

If the patient is unable to sign, please specify a valid reason (P*atient may be either mentally or physically incapable of signing due to injury….unavailability or unwillingness to sign in not an acceptable reason)*

_____***TURN OVER***