BEACON
HEALTH SYSTEM

Beacon Health Transport/Memorial MedFlight
Consent for Treatment/Signature Form

Patient's Name: _____ Date of Birth: _____ Date/Time: _____

I, or my Authorized Representative, have been advised of and consent to all transport and treatment rendered to me by **Beacon Health Transport** or **Memorial MedFlight.** I or my Authorized Representative are aware that the practice of medicine is not an exact science and we acknowledge that no guarantees have been made to me as to the results of transport care and medical treatment. I or my Authorized Representative give permission to **Beacon Health Transport** or **Memorial MedFlight** and its agents to release financial, medical and other information in written or electronic form to appropriate physicians, healthcare facilities, follow-up entities and prehospital providers to the extent reasonably required for quality review, reimbursement, or in order to assist me to secure continuity of care consistent with state and federal laws and the Health Information Privacy & Protection Act (HIPAA). We authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Beacon Health Transport** or **Memorial MedFlight**, regardless of my insurance coverage, and in some cases, may be responsible for an additional amount outside what was paid by my insurance. I or my Authorized Representative agrees to immediately remit to **Beacon Health Transport** or **Memorial MedFlight** any payments that I receive directly from insurance or any source whatsoever for the expenses of services provided to me, and I assign all rights to such payments to **Beacon Health Transport** or **Memorial MedFlight.** I or my Authorized Representative authorizes that any healthcare provider participating in my care, any holder of medical, insurance, billing or other relevant information about me from any party, database, or other source that maintains such information, to release such information to **Beacon Health Transport** or **Memorial MedFlight** 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 **Beacon Health Transport** or **Memorial MedFlight,** now, in the past, or in the future. I or my Authorized Representative understands that a refusal to release my medical information under this consent may contribute to diagnosis or treatment concerns, denial of health insurance or other benefits, or other adverse consequences. I or my Authorized Representative understands that I may review my record prior to release and refuse to disclose any part or all of the record. I or my Authorized Representative permits a copy of this authorization to be used in place of the original. I or my authorized Representative understands that I may receive a copy of this consent upon request.

COMPLETE ONLY ONE SECTION BELOW

SECTION 1 - PATIENT SIGNATURE ONLY

The patient must sign unless the patient is a minor, or is physically or mentally incapable of signing. Use Section 2 or 3 for other authorizations.

I acknowledge and consent to my medical transport and care during transport, and the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to my by **Beacon Health Transport** or **Memorial MedFlight** now, in the past, or in the future.

_____ _____
Patient Signature or Mark Date/Time

_____
Patient Printed Name

_____ _____
Witness Signature Date/Time
(Beacon Associate over 18 years old)

_____
Witness Printed Name

SECTION 2 - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section if the patient is a minor (under 18 years old) or is incapable of signing. Briefly describe the circumstances that make it impossible for the patient to sign:

_____

Patient's Legal or Authorized Representative (check one):

- ☐ Patient's Legal Parent or Guardian
- ☐ Patient's Healthcare 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 treatment or handles the patient's affairs.
- ☐ Representative of an agency or institution that did not furnish services for which payment is claimed (i.e. Ambulance Services), but furnished other care, services or assistance to the patient.

I am signing on behalf of the patient to authorize consent to my medical transport and care during transport, and the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to my by **Beacon Health Transport** or **Memorial MedFlight** now, in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed above. My signature is not an acceptance of financial responsibility for the services rendered.

_____ _____ _____
Representative Signature Date/Time Printed Name of Representative

_____
Representative's Address

SECTION 3 - BEACON HEALTH TRANSPORT/MEMORIAL MEDFLIGHT & RECEIVING FACILITY SIGNATURES

(COMPLETE THIS SECTION ONLY IF SECTION 1 & 2 ARE UNABLE TO BE COMPLETED)

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Beacon Health Transport** or **Memorial MedFlight.** *These signatures are not an acceptance of financial responsibility for the services rendered to this patient.*

Name and Location of Receiving Facility: _____

Beacon Health Transport or **Memorial MedFlight Crew Member Statement (must be completed by crew member at the 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 2 of this form were available or willing to sign on the patient's behalf.*

_____ _____ _____
Signature of Crew Member Date/Time Printed Name of Crew Member

Receiving Facility Representative Signature
The patient named on this form was received by this facility at the date and time indicated above and this facility provided care, services or assistance to the patient.

_____ _____ _____
Signature of Receiving Facility Representative Date/Time Printed Name and Title of Receiving Facility Representative

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Beacon Health Transport -or- Memorial MedFlight
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