North Whatcom Fire and Rescue
4142 Britton Loop Road, Bellingham, WA 98226
Phone 360-318-9933 www.nwfrs.net

Date: _____ **NWFR Incident #**_____

☐ **Billing Authorization:** *(required for transports)*

I,_____ request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to North Whatcom Fire and Rescue (NWFR) for any services provided to me by NWFR now or in the future. I understand that I am financially responsible for the services provided to me by NWFR, 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 NWFR any payments that I receive directly from insurance or any other source whatsoever for the services provided to me, and I assign all rights to such payments to NWFR. I authorize NWFR to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to NWFR and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by NWFR, now or in the future. A copy of this form is as valid as an original.

☐ **Refusal of Care and/or Transport:** *(required if patient refuses evaluation and/or transport)*

I,_____ being in full possession of all my faculties do hereby release NWFR, its personnel, and its medical advisors from any responsibility whatsoever for any unfavorable and untoward consequences due to my refusal accept the care/transport offered me. The possible consequences of my refusal to accept care/transport have been explained to me and I fully understand these consequences. I, the patient or legal representative, understand that should Medicaid, Medicare or any other insurance carrier determine any billable services to be not reasonable and necessary or non-covered, I will be held responsible for payment of these charges along with any remaining amount my non-contracted insurance company does not pay. I authorize release of any records necessary to process my insurance claim.

☑ **Privacy Practices Acknowledgement:** *(required for all EMS calls)*
By signing below, I acknowledge that I have received a copy of NWFR'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. If the patient is physically or mentally incapable of signing, Section II must be completed.

X _____
Patient Signature or Mark

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. Two witnesses are recommended for refusal of care/transport.

X _____ _____
1st Witness Signature 1st Witness Printed Name

X _____ _____
2nd Witness Signature 2nd Witness Printed Name

SECTION II — AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is 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 _____ _____
Representative Signature Printed Name of Representative

SECTION III — EMERGENCIES ONLY — AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** for emergency ambulance transports, if patient was physically or mentally incapable of signing, **and** no authorized representative (as listed in 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.

Reason patient incapable of signing: _____

Name and location of Receiving Facility: _____Time at Receiving Facility: _____

X _____ _____
Signature of Crew Member Printed Name of Crew Member

B. Receiving Facility Representative Signature
The above-named patient was received by this facility at the date and time indicated above.

X _____ _____
Signature of Receiving Facility Representative Printed Name of Receiving Facility Representative

C. Secondary Documentation
If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506© of HIPAA.

☐ Patient Care Report (signed by representative of facility) ☐ Facility Face Sheet / Admissions Record
☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record

White: NWFR Yellow: Patient Attn Officer: Sign to affirm form is complete and accurate: _____

NORTH WHATCOM FIRE AND RESCUE NOTICE OF PRIVACY PRACTICES

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. If you have any questions about this notice, please contact the Privacy Officer at North Whatcom Fire and Rescue (NWFR).

WHO MUST FOLLOW THIS NOTICE: This notice describes the privacy practices of North Whatcom Fire and Rescue.

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of Protected Health Information (PHI);
- Give you this notice of our legal duties and privacy practices in regard to your PHI; and
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION: The following categories describe ways that we may use and disclose health information about you, known as Protected Health Information or PHI. In most cases, this information may be released *without* your written permission to object, unless prohibited by a more stringent State law. Access to your PHI in the following categories will be on a "needs to know basis" only. The records must not be re-disclosed and appropriate measures must be taken to keep the record secure. Some of the categories include examples. Every type of use or disclosure of PHI in a particular category is not listed.

For Treatment. We may use written or verbal PHI about your medical condition and treatment that is obtained from you and others, such as, doctors and nurses who give orders to allow us to provide treatment to you. We may disclose PHI to doctors, nurses, technicians, specialists or other personnel, including people outside our facility, who may be involved in your current medical care. We may transfer your PHI by radio or telephone to the hospital or dispatch center.

For Payment. We may use and disclose PHI so that we or other providers may bill or receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health insurance carrier information about your treatment in order to make medical necessity determinations for payment or we may share PHI with the billing department or collection agency.

For Health Care Operations. We may use and disclose PHI for our health care operations. This may involve quality assurance, licensing and training programs. These uses and disclosures are necessary for your operation and management purposes and are necessary to make sure that the services we provide you are of the highest quality.

To Individuals Involved in Your Care. We may release PHI to an immediate family member or to another individual with whom you may have a close personal relationship, if we obtain your verbal agreement to do so and if you do not raise an objection verbally or in writing. If we are unable to obtain your agreement because of other circumstances, we will make the disclosure if we believe it is in your best interests and relevant to your care.

For Research. We may disclose PHI for research projects that are subject to strict approvals and oversight. The project must contain reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the project. There must be safeguards to protect the information from re-disclosure. This process evaluates a proposed research project and its use of PHI to balance the benefits of research with the need for privacy of your PHI.

For Other Circumstances Required By Law:

- For health care and legal compliance activities;
- 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 judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities, but only in very limited situations as required by law such as to avert a serious threat to the public;
- 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 or medical examiners to identify a deceased person or determine the cause of death;
- To organ and tissue donation banks as necessary to facilitate organ, tissue donation and transplantation;
- To a correctional institution or other law enforcement custodial situations that have lawful custody of you.

Other Uses and Disclosures:
Except for the purposes described above, we will use and disclose PHI only with your written authorization. You may revoke the authorization at any time, in writing, except for the PHI that we have already used or disclosed in respect to that authorization.

YOUR RIGHTS: You have the following rights in regard to your PHI, including:

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. There may be a fee for copying and it must be paid prior to access to the records. In certain limited circumstances we may deny you access to your PHI. You may appeal certain types of denials. To inspect and copy this PHI, you must make your request in writing to the Privacy Officer of NWFR.

Right to Amend. If you feel that PHI we have is incorrect, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. We are permitted by law to deny you access in certain limited circumstances. To request an amendment, you must make your request in writing to the Privacy Officer of NWFR.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of PHI we made. We are not required to give you an accounting of information we have used or disclosed for treatment, payment or health care operations or to business associates or for PHI for which you have already given us written authorization. You may request an accounting by written request to the Privacy Officer of NWFR.

Right to Request Restrictions. You have the right to request that we restrict how we use and disclose your medical information that we have about you. NWFR is not required to agree to any restrictions you request, but any restrictions agreed to by NWFR in writing are binding on NWFR. You may request confidential communications by written request to the Privacy Officer of NWFR.

Right to Confidential Communications. You have the right to request how and where we contact you about your PHI, for example, you may request that we contact you at work or only by mail. You may request confidential communications by written request to the Privacy Office of NWFR.

Internet, Electronic Mail and the Right to Obtain a Copy of Paper Notice on Request. If we maintain a website, we will prominently post a copy of this Notice on our website. If you allow us, we will forward a copy of this Notice by electronic mail instead of on paper and you may always request a paper copy of this Notice.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for the PHI we already have, as well as, any information we receive in the future. We will post a copy of the current notice in our facilities. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with NWFR or the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint. It will not change our treatment of you in any way.** To file a complaint with us, contact the Privacy Officer at NWFR.

CONTACT INFORMATION:

Privacy Officer
North Whatcom Fire and Rescue
4142 Britton Loop Rd
Bellingham, WA 98826