

Cleveland County EMS

Date: _____ Station: _____ Record #: _____

LIFETIME SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare, Medicaid or insurance benefits be made either to me or on my behalf to Cleveland County Emergency Services. I authorize any holder of Medicare, Medicaid or insurance information about me to release Centers for Medicare and Medicaid Services and its agent and carriers as well as Cleveland County Emergency Services, any information or documentation in their possession needed to determine these benefits payable for related services.

Signature Date

WAIVER OF LIABILITY ADVANCE NOTICE

Medicare will only pay for services that are determined to be reasonable and necessary under Section 1862(A)(1) of the Medicare law. If Medicare determines that a particular services, although it would otherwise be covered, is not reasonable and necessary under Medicare Program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for Cleveland County Emergency Services for the following reason:

- Not a medical necessity or Medicare covered service

I have been notified by the Emergency Medical Services staff that they believe, in my case, that Medicare is likely to deny payment for the services identified above. If Medicare denies payment, I agree to be personally and fully responsible for payment

Medicare Beneficiary Date

NOTICE OF PRIVACY PRACTICE

I have received the Cleveland County Notice of Privacy Practices (NPP).

Signature Date

Cleveland County Emergency Medical Services staff was unable to give patient their NPP because of the following:

- Unresponsive
- Acute cardio/pulmonary distress
- Altered Mental Status
- Other _____
- Trauma and related injuries
- Refused to sign
- Patient states already received NPP from Cleveland County

Physician/Nurse Signature

Treatment Authorized by: _____ MD/MICN

Patient Received by: _____

Driver Signature: _____ EMTI/EMTP

Attendant: _____ EMTI/EMTP

**CLEVELAND COUNTY EMS
REFUSAL OF SERVICE/TRANSPORT**

Date: _____ Station: _____ Record #: _____

Competent patients maintain the right to refuse medical care and/or transportation. Since you have refused our offer of recommendation to be TREATMENT TRANSPORT, we must tell you that:

- 1) You may call us back (by dialing **911**) if you change your mind or feel worse.
- 2) You are accepting full responsibility for your choice to refuse our offer to treat/transport you.
- 3) You understand what we have told you and what is printed on this form.
- 4) You agree, after consideration of having received an assessment of your medical condition, to release, indemnify and hold harmless Cleveland County EMS and its officers, agents, and employees from any and all claims, actions, damages, or liabilities of whatsoever kind or nature arising out of or in connection with your refusal of medical treatment or transportation.

Patients Signature: _____ Date: ___/___/___

Patients Name (Printed): _____ Age: _____

Since I am the patient's legal guardian in this situation, I am acting for the patient and have read the above information and refuse treatment/transport for the patient.

Guardian's Signature: _____ Date: ___/___/___

Guardian's Name (Printed): _____ Date ___/___/___ Medical Power of Attorney

I witnessed the above named patient (or legal guardian) refuse the ambulance crew's offer or recommendation to treat/transport the patient.

Witness's Signature: _____ Date: ___/___/___

Witness Name (Printed): _____

As the attending **EMTI/EMTP**, I have offered/recommended to the patient (or legal guardian) treatment/transportation to a hospital for the patient. The patient (or patient's legal guardian) refused and I believe the patient (or patient legal guardian) to be competent; he/she is alert and oriented to person, place, and time.

- I have contacted _____ (physician) at _____ (hospital) and advised him/her of the patient's/guardian's decision.
- I have explained this form to the patient (or legal guardian) and believe he/she understands it.

Signature (CCEMS Employee): _____ Date: ___/___/___

Law Enforcement Officer present Follow-up requested Refused signature Pre-hospital DNR