

DVA Ambulance, Inc.

A U T H O R I Z A T I O N F O R M

RUN # _____

LAST		FIRST		MIDDLE		DOB (MM/DD/YYYY)	
ADDRESS				CITY		STATE	ZIP
INSURANCE CARRIER				INSURANCE CARRIER			
POLICY/CONTRACT		GROUP		POLICY/CONTRACT		GROUP	
MEDICARE				AUTO CARRIER			
MEDICAID				AUTO AGENT		CITY	
MEDICAID ICD-9 CODE							

**D
V
A

A
M
B
U
L
A
N
C
E**

I request that payment of authorized Medicare/Medicaid or any insurance benefits be made either to me or on my behalf to DVA Ambulance, Inc. for any ambulance services and supplies furnished to me by DVA Ambulance, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) or any insurance carrier, their agents and carriers as well as DVA Ambulance, Inc. any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, now or in the future.

I permit a copy of this authorization may be used by DVA Ambulance, Inc. for all services in the future until such time as I revoke this authorization in writing. I also understand that if my insurance carriers do not cover this service, I acknowledge responsibility for any and all costs incurred and for payment of such services. I further understand this is a lifetime authorization, until such time I rescind the authorization in writing to DVA Ambulance, Inc.

By signing below, I further understand and consent to the use and disclosure of my protected health information by DVA Ambulance, Inc., its staff, and business associates for the purposes of treatment, payment, and health care operations as allowed under the Health Information Portability and Accountability Act of 1996. My protected health information includes any information that reasonably identifies me and relates (1) to the provision of healthcare to me, (2) to any of my past, present or future health conditions, or (3) to the past, present or future payment for any provision of healthcare to me. The information that is protected includes information related to my physical or mental health. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that DVA Ambulance, Inc. has acted in reliance on it.

NOTICE OF PRIVACY PRACTICES

As required by HIPPA, I also acknowledge receipt of DVA Ambulance, Inc. "Notice of Privacy Practices." This information is being provided to me in person or I understand that I can download this information from DVA Ambulance, Inc. website at www.dvaems.com.

SIGNATURE: _____ **DATE:** _____

CAREGIVER/THIRD PARTY AUTHORIZATION

It is my impression that the patient is physically or mentally incapable of signing. I have made the patient aware of the above information. I am NOT assuming any personal financial responsibility for this claim.
 Patient is unable to sign due to: _____

Third-Party Signature	Third-Party Printed Name	Relationship to Patient	Date
-----------------------	--------------------------	-------------------------	------

If the patient signs under Caregiver/Third-Party Authorization, Patient still agrees to assume full financial responsibility.