I, _____, consent to be treated for my medical condition(s) and/or be transported by St. Johns County Fire Rescue (SJCFR). I understand that I am financially responsible for the services provided to me by SJCFR, regardless of my insurance coverage. I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf directly to SJCFR for any and all services provided to me. I authorize and direct any holder of medical information or documentation about me to release to Medicare or Medicaid and their carriers and agents, as well as to SJCFR and its billing agents, and any other payers or insurers, any information or documentation needed to determine my benefits or benefits payable for services provided by SJCFR, now or in the future. I agree to immediately remit to SJCFR any payments I received directly from any source for the services provided to me and I assign all rights to such payments to SJCFR.

I understand that SJCFR uses my Social Security number for billing and collections purposes. I also understand that SJCFR abides by all regulations regarding protected health information (PHI) and I acknowledge that I have received a copy of SJCFR's Notice of Privacy Practices.

_____ _____
Patient or Representative Signature Date

_____ _____
Witness Signature Date

Patient unable to sign due to:_____

INSURANCE INFORMATION

Dear Patient:

You are responsible for paying your invoice unless your ambulance transport was as a result of an on the job injury. As a courtesy to you, we would be happy to file your insurance claim for your ambulance transportation, however, without proper consent and accurate information we will be unable to do so. Please provide this office with the following information within 15 days. If it is not received as requested, we will assume that you are filing your own insurance claim and that payment will be forwarded in a timely fashion or you will contact us to make payment arrangements.

Patient Name _____DOB _____

Address _____City _____State _____Zip_____

Weekday Phone No. _____Social Security #: _____

Secondary Address _____City _____State _____Zip _____

Secondary Phone No. _____

PRIMARY INSURANCE (if an auto accident, please provide Auto Company Insurance and claim#)
(If work related, please provide Company and claim# - your employer will not do this for you)

TRANSPORT RELATED TO: Auto ☐ Work ☐ Health ☐

Name of Insured _____DOB _____Social Security #_____

Name of Insurance Co. _____Insurance Phone _____

Insurance Co. Claim Address _____

Member# _____Claim# _____ Group#_____

If CHAMPUS, please write ACTIVE or RETIRED and indicate branch of service _____

If involved in an auto accident, please list automobile insurance as PRIMARY INSURANCE.

SECONDARY INSURANCE (if an auto accident, please provide Auto Company Insurance and claim#)

Name of Insured _____DOB _____Social Security #_____

Name of Insurance Co. _____Insurance Phone _____

Member# _____Claim# _____Group#_____