



## COMBINED NOTICE TO AMBULANCE PATIENTS

### HIPAA Notice of Privacy Practices

Emergency personnel with **Winchester Fire & Rescue Department** are providing you with a separate pamphlet, entitled "Notice of Privacy Practices," as required by the Code of Federal Regulations (45 CFR Section 164.520). This notice describes how medical information about you may be used and disclosed and how you can get access to such information. Please review it carefully.

**Winchester Fire & Rescue Department** is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to protect the privacy of healthcare information obtained when treating you (known as protected health information or PHI) and to provide you with a notice of privacy practices concerning the use of such information shortly following the time of service. This notice describes how and when our agency can use and disclose your PHI along with describing your legal rights pertaining to the use and disclosure of such information. This notice also provides contact information for questions and for obtaining further assistance if you need more help. Our agency is required to abide by the terms of this notice as long as it is in effect. We reserve the right to change the terms of this notice and apply such changes to all protected health information that we maintain. A copy of our current (or revised) privacy policy is always available at our business office or on our website.

By signing this form I, or the person signing for me, acknowledge receiving a "Notice of Privacy Practices" from emergency personnel with **Winchester Fire & Rescue Department**. I understand that the Notice I received explains my rights and contains information to assist me if I should have questions or a complaint.

### Permission to Use Healthcare Information for Billing Purposes and Financial Responsibility Statement

By signing this form I authorize **Winchester Fire & Rescue Department** to release any information, including protected health information or PHI, to any insurance company, insurance company representative or other authorized third party for the purpose of paying my ambulance fees and charges. I authorize any holder of healthcare information or documentation, including PHI, needed to determine benefits or benefits payable for related services or any service rendered to me now or in the future to be released to **Winchester Fire & Rescue Department** if requested. I authorize that direct payment be made by any insurance company or other third party for any ambulance fees and charges that are reimbursable and owed by me to **Winchester Fire & Rescue Department**.

By signing this form I understand that if I am insured, I am responsible for providing my insurance information to **Winchester Fire & Rescue Department** for the purpose of paying all ambulance fees and charges. I also understand that in the event I am uncooperative or refuse to provide my insurance information and/or subsequent information to support the filing of an insurance claim on my behalf, **Winchester Fire & Rescue Department** may determine that I alone must pay all ambulance fees and charges directly and that I will be responsible for paying these fees and charges within thirty (30) days of such a determination.

### NOTICE TO MEDICARE BENEFICIARIES

Current Medicare Rules and Regulations require us to notify you when services provided, or to be provided may **not** be covered by Medicare. Medicare pays for services it determines to be Reasonable and Necessary under Section 1882 (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is **not** Reasonable and Necessary under the Medicare program standards, Medicare will deny payment for that service.

At the present time, and with the information we have been able to obtain thus far, we believe that for the services you have requested, or are about to be provided to you, or that were provided to you on DATE OF SERVICE by **Winchester Fire & Rescue Department**, Medicare is likely to **deny** payment. Therefore, we are required to give notice advising you that in the event Medicare denies payment you will be responsible for payment in full.

**Please read this statement and sign:** I have been notified by **Winchester Fire & Rescue Department** that they believe that in this case Medicare is likely to deny payment for the items/services identified above, for the reason stated. If Medicare denies payment, I understand that I will be personally responsible for the account balance.

\_\_\_\_\_  
Patient or Responsible Party Name

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

**All patients please read this statement and sign:** By signing this statement I acknowledge that I have read, understand and agree to the terms and conditions explained above. Furthermore, I acknowledge receiving a separate pamphlet entitled "Notice of Privacy Practices" from emergency personnel with **Winchester Fire & Rescue Department** explaining HIPAA and my rights as described by the law.

\_\_\_\_\_  
Patient or Responsible Party Name

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

Incident/Call/Report Number: \_\_\_\_\_