

Billing Signatures Requirements in ImageTrend

The AIC must sign every incident

- Signature Reason will be: **Other**
- Language: **English**
- Type of Person: **Attendant in Charge (For this Event)**
- Typed First and Last Name
- Date and Time

Signature

Signature Reason:

Refusal of Care/Transport	HIPAA acknowledgement Release	Release for Billing
Controlled Substance, Administration	Controlled Substance, Waste	Other

Language:

Type of Person Signing:

Attendant in Charge (For this event)



Signature First Name:

Signature Last Name:

Date/Time of Signature:

When a Patient Signs:

- Signature Reason: **Release for Billing**
- Type of Person Signing: **Patient**
- Type of Patient Representative: **Self**
- Typed First and Last Name
- Date and Time

Signature

Signature Reason:

Refusal of Care/Transport	HIPAA acknowledgement Release	Release for Billing
Controlled Substance, Administration	Controlled Substance, Waste	Other

Language:

Type of Person Signing:

Patient

Type Of Patient Representative:

Self



Signature First Name:

Signature Last Name:

Date/Time of Signature:

When a Patient Representative Signs

- Signature Reason: **Release for Billing**
- Type of Person Signing: **Patient Representative**
- Type of Patient Representative: **Select Applicable Person**
- Signature First Name: **Type the Reason why the patient is unable to sign!**
- Signature Last Name: **Type the Full Name of the person signing!**
- Date and Time

Signature

Signature Reason:

Refusal of Care/Transport	HIPAA acknowledgement Release	Release for Billing
Controlled Substance, Administration	Controlled Substance, Waste	Other

Language:

Type of Person Signing: Patient Representative

Type Of Patient Representative: Power of Attorney



Signature First Name:

Signature Last Name:

Date/Time of Signature:

When a Healthcare Provider Signs

- Signature Reason: **Release for Billing**
- Type of Person Signing: **Patient Representative**
- Type of Patient Representative: **Select Applicable Person**
- Signature First Name: **Type the Reason why the patient is unable to sign!**
- Signature Last Name: **Type the Full Name of the person signing!**
- Date and Time

Signature

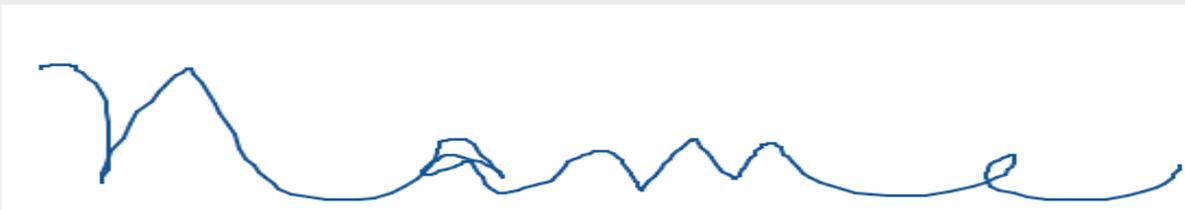
Signature Reason:

Refusal of Care/Transport	HIPAA acknowledgement Release	Release for Billing
Controlled Substance, Administration	Controlled Substance, Waste	Other

Language:

Type of Person Signing: Healthcare Provider

Type Of Patient Representative: Nurse (RN)



Signature First Name:

Signature Last Name:

Date/Time of Signature: