



COMBINED NOTICE TO AMBULANCE PATIENTS

HIPAA Notice of Privacy Practices

Emergency personnel with the Fauquier County 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.

Fauquier County 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 Fauquier County. 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 Fauquier County 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 Fauquier County 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 Fauquier County.

If I am insured by a federal health insurance plan, such as Medicare or other forms of federal health insurance, by signing this form I authorize Fauquier County to release any information, including PHI, to the Department of Health and Human Services, the Center for Medicare and Medicaid Services or their contracted agents, for the purpose of paying my ambulance fees and charges. I understand that such insurance plans require a co-payment or even a deductible that I or my supplemental insurance may be responsible for paying.

If I am an active duty member of the United States Military, I authorize Fauquier County to release any information, including PHI, to the Department of Defense or my command upon written request by appropriate authority.

Finally, by signing this form I understand that if I am insured, I am responsible for providing my insurance information to Fauquier County 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, Fauquier County 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.

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 Fauquier County 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: _____

PCR Form Number: _____

Patient unable to sign due to the following reason:

Notice provided to individual listed below:

Relationship:

Crew Initials:
