SMMS ALTERNATIVE SIGNATURE ATTESTATION

PO Box 2290 ● 346 S. Peshlakai Ave, Suite B ● Tuba City, AZ 86045 ● Office (928) 283-8243 ● Fax (928) 283-8300

Patient Name		Transport Date	

SECTION I – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section ONLY if the patient is physically or mentally incapable of signing, **but** an authorized representative, other than a parent or legal guardian, is available or willing to sign on behalf of the patient at the time of service.

Describe the circumstance that make it impractical for the patient to sign: ____

____

I am signing on behalf of the patient to authorize care and treatment and the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by SMMS now, or in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. ***My signature is not an acceptance of financial responsibility for the services rendered.***

Authorized representative includes only the following individuals:

- ☐ Immediate family member, including a sibling, grandparent, grandchild or step-parent.
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient.
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs.
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e. ambulance services) but furnished other care, services, or assistance to the patient.

Representative Signature	Date	Printed Name of Representative

SECTION II – AMBULANCE CREW AND RECEIVING / SENDING FACILITY SIGNATURES

Complete this section ONLY if: (1) the patient was physically or mentally incapable of signing, **and** (2) no authorized representative (Section I) was available or willing to sign on behalf of the patient at the time of service.

Describe the circumstance that make it impractical for the patient to sign: ____

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Name of Facility: ____ Time: ___________________

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by SMMS.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives, to include parent or legal guardian and those listed in Section I of this form, were available or willing to sign on the patient's behalf.

Signature of Crewmember	Date	Printed Name and Title of Crewmember

B. Facility Representative Signature

The patient named on this form was seen by this facility on the date and at the time indicated, and this facility furnished care, services or assistance to the patient who at the time was physically or mentally incapable of signing. ***My signature is not an acceptance of financial responsibility for the services rendered.***

Signature of Facility Representative	Date	Printed Name and Title of Facility Representative

Privacy Practice Acknowledgement: by signing above, the signer acknowledges that Sacred Mountain Medical Services (SMMS) provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. **A copy of this form is valid as an original.**