



SMMS ALTERNATIVE SIGNATURE ATTESTATION

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Patient Name	Transport Date
SECTION I – AUTHORIZED REPRESENTATIVE SIGNATURE	
<p>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.</p>	
<p>Describe the circumstance that make it impractical for the patient to sign: _____</p> <p>_____</p>	
<p>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. <i>My signature is not an acceptance of financial responsibility for the services rendered.</i></p>	
<p>Authorized representative include only the following individuals:</p> <ul style="list-style-type: none"><input type="checkbox"/> Immediate family member, including a sibling, grandparent, grandchild or step-parent.<input type="checkbox"/> Relative or other person who receives social security or other governmental benefits on behalf of the patient.<input type="checkbox"/> Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs.<input type="checkbox"/> 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 FACILITY SIGNATURES		
<p>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.</p>		
<p>Describe the circumstance that make it impractical for the patient to sign: _____</p> <p>_____</p>		
<p>Name of Receiving Facility: _____ Time: _____</p>		
<p>A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by SMMS.</p>		
<p>A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)</p> <p>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.</p>		
_____ Signature of Crewmember	_____ Date	_____ Printed Name and Title of Crewmember
<p>B. Receiving Facility Representative Signature</p> <p>The patient named on this form was received 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. <i>My signature is not an acceptance of financial responsibility for the services rendered.</i></p>		
_____ Signature of Receiving Facility Representative	_____ Date	_____ Printed Name and Title of Receiving 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.**