TRANSPORT NUMBER _____

PATIENT _____

PATIENT CONSENT TO TRANSPORT

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I consent to transport and treatment by **Life Flight Network, LLC** ("Provider"), including the administration of blood, blood products and blood derivatives and any other treatment deemed necessary in the judgment of Provider's medical crew. I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Provider now, in the past, or in the future, until I revoke this authorization in writing. I understand I am financially responsible for the services provided to me by Provider, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what was paid by my insurance. I agree to immediately remit to Provider any payments I receive directly from insurance or any source whatsoever for the services provided to me, and I assign all rights to such payments to Provider. I authorize Provider to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing, or other relevant information about me to release such information to Provider and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Provider, now, in the past, or in the future. I also authorize Provider to obtain medical, insurance, billing, and other relevant information about me from any party, database, or other source that maintains such information.

X_____ _____
Patient Signature or Mark **Date**

X_____ _____
LFN Crew Signature (***only if Pt signs by mark***) Date
22285 Yellow Gate Lane Ste. 102
Aurora, OR 97002

For Known or Suspected COVID-19 Patient Only

☐ **CHECK HERE** if patient gave verbal consent for LFN crew to sign.

_____ _____
LFN Crewmember Signature Date
(Crewmember should sign own name and not pt's name)

_____
LFN Crewmember's Printed Name

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Provider now, in the past, or in the future. By signing below, I acknowledge I am one of the authorized signers listed below.

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian
- ☐ 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 or transport services) but furnished other care, services, or assistance to the patient

X_____ _____ _____
Representative Signature Date Printed Name of Representative

*If I am signing on the patient's behalf, I understand that signing does not make me personally responsible to pay for the services rendered.

[OVER]

SECTION III – LFN CREW AND RECEIVING FACILITY SIGNATURES

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

Describe the circumstances that make it impractical for the patient to sign: _____

Name and Location of Receiving 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 Provider.

A. LFN Crewmember Statement (*must* be completed by crewmember at time of transport)

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

X_____ _____ _____

Signature of LFN Crewmember | Date | Printed Name and Title of LFN Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility on the date and at the time indicated and this facility will furnish care, services, or assistance to the patient.

X_____ _____ _____

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

*If I am signing on the patient's behalf, I understand that signing does not make me personally responsible to pay for the services rendered.