

**Bangs Ambulance, Inc.**  
**P.O. Box 6445**  
**Ithaca, NY 14851-6445**  
**(607)277-4911**

**PLEASE READ CAREFULLY!!!**

Please fill out the information below and return it by mail to us at the above address or fax it to 607-277-9281.

**Insurance Information:**

If you have insurance or you were involved in a motor vehicle accident, please provide us with the information so we can submit your claim on your behalf.

Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Co Phone : \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Claim #: \_\_\_\_\_

Date of Transport: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature Authorization Form**

**Section One - Authorization and Receipt of Notice of Privacy Practices**

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Bangs Ambulance (Bangs) for any services provided to me by Bangs now or in the future. I understand that I am financially responsible for the services provided to me regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by insurance. I agree to immediately remit to Bangs any payments that I receive directly from insurance or any other source whatsoever for the services provided to me and I assign all rights to such payments to Bangs. I authorize Bangs to appeal payment denials or other adverse decisions on behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Bangs and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Bangs, now or in the future. A copy of this form is a valid as the original.

By signing below I acknowledge that I have received the Bangs Ambulance Notice of Privacy Practices.

Patient Name \_\_\_\_\_

X \_\_\_\_\_

**Section Two - Authorized Signer - complete ONLY if the patient is unable to sign.**

**Authorized Signer Statement**

An authorized signer include ONLY the following individuals – check one

- Patient's Legal Guardian  Patient's Health Care Power of Attorney  
 Relative or other person who receives government benefits on behalf of the patient  
 Relative or other person who arranges medical care or handles other affairs for the patient

As an authorized signer I recognize that signing on behalf of the patient is not an acceptance of financial or any responsibility for service rendered. In my opinion the patient is physically or mentally incapable of signing for the following reason:

\_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_