**Assignment of Benefits Authorization, Responsibility for Payment, Acknowledge of Receipt of Notice of Privacy Practices and, Treatment and Transport Refusal**

1. **The undersigned has carefully read the release, fully understands it, and signs this as a free and voluntary act.**
2. **I understand that Delaware County Emergency Medical Service was summoned to my aid and I choose not to receive further examination, medical treatment, or transportation to a hospital by Delaware County Emergency Medical Service an EMS provider. I also understand that although I may currently feel fine, I may have suffered a serious physical injury and/or disease to my person leading to severe disability and/or death. I knowingly and voluntarily accept full responsibility for this decision and forever release and discharge from liability Delaware County, Indiana for any adverse events I may experience. Lastly, I understand that if any problems develop, I should seek medical care immediately and that I may call 911 at any time I feel an emergency exists.**
3. **At this time I am making this decision with appropriate mental capacity, and I understand and I am able to verbalize my understanding of the risk benefits, options, alternatives, possible consequences of refusal of care, and the potential of morbidity (significant disability) and mortality (death) from my refusal of further medical care.**
4. **I am assuming full responsibility for my continuing medical care. I agree that I will not hold Delaware County EMS, its employees, agents, directors, officers, and insurers responsible for any damages, actions claims, cost or expense that may arise as a result of my refusal to accept the medial services that have been offered to me.**
5. **I understand I may call 911 at any time if I change my mind and wish to be taken to the hospital and that I am financially responsible for the services provided to me by Delaware County EMS regardless of insurance coverage.**
6. **I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Delaware County Emergency Medical Service for any services provided to me by Delaware County Emergency Medical Service personnel.**
7. **I authorize Medicare and Medicaid Services and its carriers and agents, as well as to Delaware County Emergency Medical Service and its billing agents and any other payers or insurers, and information or documentation needed to determine these benefits or benefits payable for any services provided to me by Delaware County Emergency Medical Service.**
8. **I also authorize this ambulance service and its billing agent to appeal claim determinations on my behalf.**
9. **I acknowledge that I have received a copy of the Delaware County Emergency Medical Service Notice of Privacy Practices. I authorize a copy of this form may act as the original.**

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative Signature or Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_