Harnett County Emergency Medical System
Assignment of Benefits Authorization, Responsibility for Payment and Acknowledgement of Receipt of Notice of Privacy Practices

BILLING AUTHORIZATION, RESPONSIBILITY FOR PAYMENT AND RECEIPT OF NOTICE OF PRIVACY RIGHTS

I understand that I am financially responsible for the services provided to me by Harnett County Emergency Medical System regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Harnett County Emergency Medical System for any services provided to me by Harnett County Emergency Medical System. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to Harnett County Emergency Medical System and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Harnett County Emergency Medical System, now or in the future. I agree to immediately remit to Harnett County Emergency Medical System any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to Harnett County Emergency Medical System.

I also acknowledge that I have read and/or received a copy of the Harnett County Emergency Medical System HIPAA Notice of Privacy Practices. A copy of this form is as valid as the original.

Patient Name: _____

Patient Mailing Address: _____

_____

Patient Date of Birth: _____

_____ Date: _____
Patient Signature

_____ _____
Patient Representative's Signature Relationship to Patient

Patient unable to sign due to: _____

EMS Department: Harnett County EMS

Trip Number: _____