APOLLO MedFlight

PATIENT CONSENT & ASSIGNMENT OF BENEFITS

Patient Name:_____Transport Number:_____ Date of Transport:_____

As a condition of receiving air medical transport and treatment by Apollo MedFlight LLC, I hereby agree to the following:

1) **Consent to Treatment:** I am suffering from a condition requiring medical treatment and transport. I consent to transport and treatment by Apollo MedFlight LLC (the "Provider"), including the administration of blood, blood products and blood derivatives and any other treatment deemed necessary in the judgment of Provider medical crew (the "Services"). I am aware that the practice of medicine is not an exact science. No representations or guarantees have been made regarding the Services.

2) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other private or public insurance carrier(s) or third party insurance carrier (collectively, "Insurance Carriers") have been obtained. I recognize that my Insurance Carrier may reduce benefits if these are not obtained and that I am responsible for any balance not paid by it, or if I have no insurance, I will be personally and fully responsible for payment of Provider's charges. I recognize that some or all of the Services may be deemed not medically necessary by my Insurance Carrier, or fail to meet other coverage requirements, and that in such event, I may be responsible for the entire unpaid balance of Provider's charges. I agree to sign any documents necessary to authorize Provider to contest any insurance denial. I agree that, in the event my Insurance Carrier pays me for Services Provider provided, I will pay such amounts to Provider.

3) **Guarantee of Payment and Assignment of Benefits:** I request and authorize direct payment to Provider of any Medicare and other insurance benefits payable to me or on my behalf from Insurance Carriers for Services provided by Provider, now or in the future. I agree to pay Provider charges for the Services, including but not limited to any co-payments, deductibles or other expenses not covered by insurance. Unless otherwise specifically agreed in writing or provided by law, all charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 18% per annum, not to exceed the maximum amount permitted by law. Without limiting the foregoing, to the full extent necessary to pay Provider charges in full, and subject to any limitations imposed by applicable law, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits (whether such insurance is owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the injury or medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the injury or medical condition which necessitated the Services. I further assign Provider the (1) the right to file a claim for benefits with any Insurance Carrier to recover for the Services provided to me; (2) the right to appeal any adverse determination on said claim; (3) the right to obtain all documentation relevant to Provider's claim, including but not limited to a copy of my insurance policy; (4) the right to demand and receive the production of or access to any documents or information from any entity or person to the fullest extent of my rights to do so under applicable laws; and (5) the right to pursue all legal and equitable claims and remedies, including but not limited to claims for the breach of the Texas Insurance Code or breach of fiduciary duty. I hereby authorize Provider to file a lien to secure its right to payment for the Services it has provided to me, which secured interest shall attach and also be automatically perfected effective as of the date and time that my condition first arose. I further authorize Provider to file the form(s) normally filed with the secretary of state or other governmental agency relating to such secured interests, and to make such filings in all relevant jurisdictions as Provider sees fit in its sole discretion, and agree that, notwithstanding Texas Property Code 55.004 (f), any such lien shall be for the entire amount charged by Provider for the services provided to me. I further agree that Provider shall have an equitable lien and secured claim against any and all insurance proceeds, settlement proceeds, or judgments in favor of me or my legal representatives up to the amount charged by Provider for the Services provided to me. To the full extent permitted by law, I specifically instruct any attorney, insurance agent, or other party who represents me to abide by this assignment and to disburse from the attorney's trust account or other depository to Provider any insurance proceeds necessary to pay Provider's charges in full. I also assign and request payment of authorized Medicare, Medicaid or other government and private health benefits be made directly to Provider. Acceptance of this assignment by Provider shall not constitute an undertaking by Provider or any duty to secure payment of any of the benefits hereby assigned. This assignment shall not be deemed to be in substitution for any right or remedy which Provider may have to secure and obtain full payment of its charges directly from the undersigned. All rights and remedies of Provider pursuant to this agreement and by law are cumulative and the exercise of any right or remedy shall not be to the exclusion of the exercise of any other right or remedy.

4) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal valuables or belongings brought into the ambulance by me or my representative, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aides, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.

5) **Consent for Release and Use of Information:** I authorize any holder of medical or other information (including medical records) about me to release to Provider, Medicare, Medicaid or any other Insurance Carrier or their agents any information needed to determine benefits for this or a related claim, or for any other purpose permitted by law. This authorization includes any other healthcare provider, including a physician or hospital or any other covered entity, and I direct them to provide any medical records relevant to the Services provided to me to Provider upon request by Provider. I authorize Provider to obtain a credit report to assist in the collection of any unpaid balances or for any other purpose. I authorize Provider to use or disclose any medical or other information for any purpose permitted by law, including the payment of Provider's claims. I consent to the use of a copy of this authorization in lieu of the original.

6) **Acknowledgement of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider Notice of Privacy Practices.

7) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for the purpose of obtaining police reports and other data related to the accident or incident for which Services were provided.

8) **Severability; Entire Agreement; Attorney's Fees:** In the event any provision of this Agreement is held to be invalid or unenforceable by a court of competent jurisdiction, such finding shall have no effect upon the validity or enforceability of the remaining portions hereof. The invalid or unenforceable provision shall be deemed severed and the remaining provisions hereof shall remain in full force and effect. This Agreement constitutes the entire agreement between Provider and the undersigned. If any action at law or in equity is brought to enforce this Agreement, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred. I the undersigned have read this Agreement, have had an opportunity to ask any questions I have, and have received satisfactory answers thereto and enter into it voluntarily. Any revisions, strike throughs, handwritten language or other changes to the typewritten text cannot be made except by another mutually signed agreement. Any such modifications without a mutually signed agreement are null and void and non-enforceable.

1. Patient's Signature: _____Printed Name: _____Date: _____

2. IF patient is physically or mentally incapable of signing, an authorized representative may sign on patient's behalf

WHY is Patient Incapable of Signing? _____

Authorized Representative Signature*:_____ Printed Name: _____Date: _____

**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.*

Please indicate the relationship of the authorized representative:

- ☐the patient's legal guardian;
- ☐a relative or other person who receives governmental benefits on the patient's behalf;
- ☐a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs;
- ☐a representative of an agency or institution which furnished other care or services to the beneficiary

3. IF patient is physically or mentally incapable of signing AND no authorized representative, from the list above, was available or willing to sign, then a Crew Member AND a Receiving Facility Representative may sign on patient's behalf

WHY is Patient Incapable of Signing? _____

A) Crew Member Signature*: _____Date_____ Printed Name & Title _____

**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.*

AND

B) Receiving Facility Rep Signature*: _____Date_____ Printed Name & Title _____

**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.*

AND

C) Name of Receiving Facility _____Date & Time at Receiving Facility: Date _____Time _____