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Background Information

The transport examples in the coding clinics were performed by "Mickey Mouse Ambulance," a fictional, private, non-profit ambulance service serving the fictional "Magic Kingdom." Mickey Mouse Ambulance has 6 vehicles, with six crew teams, as identified below. Within the Magic Kingdom are the fictional cities of Atlantica, Radiator Springs, Frontierland, Tomorrowland, Neverland, Fantasyland, Monstropolous, and Zootopia, as outlined on the attached map. The facilities and locations (other than private residences) where trips originate or end are listed below, and also appear on the map. In this Coding Clinic, we are deciding how to code these transports and to which payer the transports should be billed. In cases where the transport is not billable to Medicare (based on the information available for review) we must decide what steps to take.

Ambulance Crew Member Signature Log

<table>
<thead>
<tr>
<th>Unit #</th>
<th>Crew Member Name</th>
<th>Signature Specimen</th>
<th>Certification Level</th>
<th>Certification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Peter Pan</td>
<td>Peter Pan</td>
<td>EMT-Paramedic</td>
<td>P-00755</td>
</tr>
<tr>
<td></td>
<td>Tinker Bell</td>
<td>Tinker Bell</td>
<td>EMT-Paramedic</td>
<td>P-00377</td>
</tr>
<tr>
<td>2</td>
<td>Donald Duck</td>
<td>Donald Duck</td>
<td>EMT-Paramedic</td>
<td>P-00031*</td>
</tr>
<tr>
<td></td>
<td>Daisy Duck</td>
<td>Daisy Duck</td>
<td>EMT-Basic</td>
<td>B-00014</td>
</tr>
<tr>
<td>3</td>
<td>Sebastian Mon</td>
<td>Sebastian Mon</td>
<td>EMT-Paramedic</td>
<td>P-00823*</td>
</tr>
<tr>
<td></td>
<td>Flounder Ing</td>
<td>Flounder Ing</td>
<td>EMT-Basic</td>
<td>B-00046</td>
</tr>
<tr>
<td>4</td>
<td>Hans Southern</td>
<td>Hans Southern</td>
<td>EMT-Basic</td>
<td>B-00369</td>
</tr>
<tr>
<td></td>
<td>Kristoff Anderson</td>
<td>Kristoff Anderson</td>
<td>EMT-Basic</td>
<td>B-00123</td>
</tr>
<tr>
<td>5</td>
<td>Celia Weelia</td>
<td>Celia Weelia</td>
<td>EMT-Basic</td>
<td>B-00598</td>
</tr>
<tr>
<td></td>
<td>James P. Sullivan</td>
<td>Sully</td>
<td>EMT-Basic</td>
<td>B-00623</td>
</tr>
<tr>
<td>6</td>
<td>Dopey Dwarf</td>
<td>Dopey Dwarf</td>
<td>EMT-Basic</td>
<td>B-00765</td>
</tr>
<tr>
<td></td>
<td>Happy Dwarf</td>
<td>Happy Dwarf</td>
<td>EMT-Paramedic</td>
<td>P-00978</td>
</tr>
</tbody>
</table>

* Advanced paramedic scope of practice includes: arterial line monitoring, ventilator operations and the following medication administrations: blood and blood products, antibiotic infusions, and heparin.
<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Center</strong></td>
<td>Trauma Center and 1,000 Bed Hospital 1 Magic Kingdom Way, Fantasyland 99916</td>
</tr>
<tr>
<td><strong>General Hospital</strong></td>
<td>500 Bed Hospital w/ ER 10 Atlantica View Rd., Neverland 99915</td>
</tr>
<tr>
<td><strong>Good Samaritan Hospital</strong></td>
<td>200 Bed Hospital w/ ER 14 Randall Dr., Monstropolis 99917</td>
</tr>
<tr>
<td><strong>Holy Spirit Hospital</strong></td>
<td>150 bed hospital w/ separate specialty center 100 14th St. Radiator Springs, 99912</td>
</tr>
<tr>
<td><strong>Community Hospital</strong></td>
<td>25 Bed Hospital and ER 6467 Race St., Zootopia, 99918</td>
</tr>
<tr>
<td><strong>Select LTACH</strong></td>
<td>10 Bed SNF, 20 Bed Hospital inside Holy Spirit Hospital (4th Floor) 100 14th St. Frontierland, 99913</td>
</tr>
<tr>
<td><strong>Golden SNF</strong></td>
<td>75 Bed SNF, with Hospice Care 2319 Sock Dr., Monstropolis, 99917</td>
</tr>
<tr>
<td><strong>End of the Road SNF</strong></td>
<td>100 Bed SNF &amp; Hospice Care 17 Main St. Fantasyland, 99916</td>
</tr>
<tr>
<td><strong>Magic SNF</strong></td>
<td>100 Bed SNF and Assisted Living Facility 1501 Oswald St., Fantasyland, 99916</td>
</tr>
<tr>
<td><strong>Assisted Living</strong></td>
<td>Personal Care Home, no skilled services offered 42 Wallaby Way, Atlantica, 99914</td>
</tr>
<tr>
<td><strong>Dialysis Center</strong></td>
<td>Dialysis Center (not hospital based) 7878 Creek Run Road Frontierland 99913</td>
</tr>
<tr>
<td><strong>Outpatient Center/Freestanding Clinic</strong></td>
<td>Ambulatory surgery, diagnostic services, Freestanding ED services Highway 15 North, Frontierland 99913</td>
</tr>
<tr>
<td><strong>Apartment Complex</strong></td>
<td>150 Units 500 Dwarf Street, Fantasyland 99916</td>
</tr>
<tr>
<td><strong>Power Plant</strong></td>
<td>2320 Atlantica View Rd., Neverland 99915</td>
</tr>
<tr>
<td><strong>Hotel</strong></td>
<td>99 Olaf St., Zootopia, 99918</td>
</tr>
<tr>
<td><strong>Urgent Care Clinic</strong></td>
<td>2004 Incredible Dr., Tomorrowland, 99911</td>
</tr>
<tr>
<td><strong>County Jail</strong></td>
<td>1001 Acorn Way, Monstropolis, 99917</td>
</tr>
</tbody>
</table>
Magic Kingdom - Response Determinants and Dispatch Codes

Response/Transport Priority
Alpha – BLS Cold (Non-emergency)
Bravo – BLS Hot
Charlie – ALS Cold (Non-emergency)
Delta – ALS Hot
Echo – ALS Hot

Dispatch Codes
001 – Cardiac/ Heart Problems (ALS)
002 – Respiratory/Breathing Problems (ALS)
003 – Fall – greater than 10 feet (ALS)
004 – Fall – less than 10 feet (BLS)
005 – Animal Bite – with other symptoms (ALS)
005 – Animal Bite – no other symptoms (BLS)
006 – Fracture – with other symptoms (ALS)
007 – Fracture – without other symptoms (BLS)
008 – Gunshot/ Stab Wound – dangerous body part/ bleeding not under control (ALS)
009 – Gunshot/ stab wound – not dangerous body part/ bleeding under control (BLS)
010 – Hemorrhage/ Bleeding – dangerous body area or 2” symptoms (e.g. vomiting/ pain) (ALS)
011 – Hemorrhage/ bleeding – not dangerous body area or minor bleeding (BLS)
012 – Seizure Activity (ALS)
013 – Altered Mental State – other symptoms (ALS)
014 – Altered Mental State – no other symptoms (BLS)
015 – Sick Person, Man Down, unknown status (ALS)
016 – Sick Person, known status, minor condition (BLS)
017 – CVA/ Stroke (ALS)
018 – Mass/ Multiple Trauma (ALS)
019 – Fever – no other symptoms (BLS)
020 – Pain – no other symptoms < 4/10 on pain scale (BLS)
021 – Pain – other symptoms, >4/10 on pain scale (ALS)
022 – Choking – alert, awake, no other symptoms (BLS)
023 – Diabetic Problems (BLS)
024 – Eye Problem (BLS)
025 – Headache (BLS)
026 – Syncope/ Vertigo (BLS)
027 – Pregnancy/ Childbirth (BLS)
028 – Overdose (ALS)
029 – Psychiatric/ Suicidal (BLS)
030 – Heat/ Cold Exposure (BLS)
031 – Burns 1st degree or less than 10% of body (BLS)
032 – Burns 2nd or 3rd degree or greater than 10% of body (ALS)
033 – Non-emergency Interfacility Transfer / Palliative Care / Discharge
034 – Welfare Check (BLS)

Approved: Mickey Mouse, MD, CEO Date: 7/1/2015
Magic Kingdom Department of Health - Approved ALS Drugs

1. Activated Charcoal
2. Adenosine
3. Albuterol
4. Amiodarone
5. Aspirin
6. Atropine
7. Calcium Chloride
8. Diazepam
9. Dilaudid
10. Diltiazem
11. Diphenhydramine HCL
12. Epinephrine
13. Fentanyl
14. Furosemide
15. Glucagon
16. Intravenous solutions (Dextrose, NaCl, Lactated Ringer’s)
17. Lidocaine
18. Lorazepam
19. Magnesium Sulfate
20. Midazolam
21. Morphine
22. Naloxone HCL (Narcan) IV
23. Nitroglycerin
24. Ondansetron
25. Sodium bicarbonate

* EMT-B scope of practice includes transport of a patient with an existing IV lock, O₂ administration, BGL check, and Narcan administration IM.

Signed:

Walt Disney, MD Medical Director, Magic Kingdom Department of Health

Effective Date: 7/1/2015
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Run 101-E
**Patient Care Report**

**RUN NUMBER:** 101E  
**PATIENT NAME:** Madame Medusa  
**DATE OF SERVICE:** 6/13/16

<table>
<thead>
<tr>
<th>Times</th>
<th>Response Information</th>
<th>Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL RECVD</td>
<td>03:12:14</td>
<td></td>
</tr>
<tr>
<td>DISPATCH</td>
<td>03:13:11</td>
<td></td>
</tr>
<tr>
<td>ENROUTE</td>
<td>03:13:41</td>
<td></td>
</tr>
<tr>
<td>ON SCENE</td>
<td>03:22:33</td>
<td></td>
</tr>
<tr>
<td>DEPART SCENE</td>
<td>03:31:18</td>
<td></td>
</tr>
<tr>
<td>ARRIVE DEST.</td>
<td>03:39:57</td>
<td></td>
</tr>
</tbody>
</table>

**DISPATCH CODE:** 015 – Sick person  
**RESPONSE PRIORITY:** Delta  
**LOCATION:** County Jail, Monstropolous  
**TRANSPORTED TO:** Medical Center, 1 Magic Kingdom Way, Fantasyland,  
**TRANSPORT PRIORITY:** Alpha  
**DISPATCH COMMENTS:** Ill female in front of jail

**Demographic**

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>AGE</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madame Medusa</td>
<td>10/29/50</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td>No permanent address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td>F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Initial Information**

<table>
<thead>
<tr>
<th>CHIEF COMPLAINT</th>
<th>PT FOUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other – psych episode</td>
<td>Sitting on curb outside jail</td>
</tr>
</tbody>
</table>

**MEDICAL HX**

- Anxiety, Psychiatric, PTSD

**ALLERGIES**

- NKDA

**IMPRESSION**

- Psychosis

**Narrative**

Medic unit 3 dispatched Delta for an ill female at County Jail, complaining of psych problems. Pt. stated she was released from jail approximately 30 minutes prior to our arrival. Pt. reported the episode started as soon as she was released, reporting that “my brain says one thing, but my mouth says another.” She also noted she was tired of being homeless and unable to protect herself. Pt. is fully conscious and oriented. Pt. denies chest pain, SOB, NV, abdominal pain, HA, dizziness, weakness, numbness, or tingling. Breathing is w/n/l with no accessory muscle use, with clear, equal lung sounds bilaterally. Skin is normal color, temperature, and moisture. Radial pulse is strong and regular. Pupils are PEARL. Abdomen is soft, non-tender upon palpation, with no masses or rigidity noted. Pt. moves all extremities with good distal CSM. Remainder of detailed physical head to toe physical assessment is unremarkable.

Pt. was able to stand and walk from the curb and climb into the back of the unit without issue. Pt. remained on bench seat for duration of transport. Pt. vitals were taken and base contact was made with no questions or orders from hospital. Upon arrival at Medical Center, pt. was able to gather herself out of the unit and walk to Room 7 where EMS crew gave complete report to the RN on staff. Pt. had no belongings. Pt. care transferred to hospital, with no further pt. contact.

**Treatment Log**

<table>
<thead>
<tr>
<th>TIME</th>
<th>B/P</th>
<th>HR</th>
<th>RR</th>
<th>SPO2</th>
<th>TEMPERATURE</th>
<th>EXAM (NEURO, RR, CV, ABD, SKIN)</th>
<th>TREATMENT (O2, MED, PIV, EXTRICATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>03:30</td>
<td>120/82</td>
<td>94</td>
<td>16</td>
<td>97%</td>
<td>35.0</td>
<td>GCS= E4 + V5 + M5 = 15</td>
<td>ALS assessment, A&amp;Ox4</td>
</tr>
<tr>
<td>03:35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Base contact – no orders given</td>
</tr>
<tr>
<td>03:37</td>
<td>124/76</td>
<td>81</td>
<td>16</td>
<td>97%</td>
<td>35.0</td>
<td>PEARL, GCS=15</td>
<td>Transfer of care to ER staff</td>
</tr>
<tr>
<td>03:41</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Crew Information**

<table>
<thead>
<tr>
<th>Lead</th>
<th>Sebastian Mon</th>
<th>CERT#</th>
<th>P-00823</th>
<th>LEVEL</th>
<th>P</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver</td>
<td>Flounder Ing</td>
<td>CERT#</td>
<td>B-00046</td>
<td>LEVEL</td>
<td>B</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>

Sebastian Mon  
Flounder Ing
Mickey Mouse Ambulance Signature/Claim Submission Authorization Form

Patient Name: Madame Medusa  Transport Date: 6/13/16

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

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 authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mickey Mouse Ambulance now, in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

X Madame Medusa  6/13/16  Flounder Ing  6/13/16
Patient Signature or Mark Date Witness Signature Date

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 only if 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 Mickey Mouse Ambulance now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

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 services) but furnished other care, services, or assistance to the patient

X
Representative Signature Date Printed Name of Representative

SECTION III - AMBULANCE 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 Mickey Mouse Ambulance.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. My signature is not an acceptance of financial responsibility for the services rendered.

X
Signature of Crewmember Date Printed Name and Title of 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 furnished care, services or assistance to the patient. My signature is not an acceptance of financial responsibility for the services rendered.

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

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.
2016-2017 Program Materials

Run 102-E
**Patient Care Report**

**Run Number:** 102 E  
**Patient Name:** Hank Septopus  
**Date of Service:** 7/31/16

<table>
<thead>
<tr>
<th>Times</th>
<th>Response Information</th>
<th>Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Recv’d</td>
<td>04:27:10</td>
<td></td>
</tr>
<tr>
<td>Dispatch</td>
<td>04:28:37</td>
<td></td>
</tr>
<tr>
<td>Enroute</td>
<td>04:30:39</td>
<td></td>
</tr>
<tr>
<td>On Scene</td>
<td>04:35:19</td>
<td></td>
</tr>
<tr>
<td>Depart Scene</td>
<td>04:50:59</td>
<td></td>
</tr>
<tr>
<td>Arrive Dest.</td>
<td>04:55:31</td>
<td></td>
</tr>
</tbody>
</table>

**Dispatch Code:** 019 – Fever (BLS)  
**Response Priority:** Bravo  
**Location:** 21637 Augusta Dr., Zootopia 99918  
**Transported To:** Community Hospital, Zootopia, 99918  
**Transport Priority:** Charlie  
**Total Loaded Mileage:** 1.5

**Dispatch Comments:** Excessive vomiting

**Demographic**

| NAME          | Hank Septopus  
| DOB           | 6/10/1940  
| AGE           | 76  
| WEIGHT        | 160  
| ADDRESS       | 21637 Augusta Dr., Zootopia 99918  
| SEX           | M

**Initial Information**

| Chief Complaint | Nausea/vomiting, Dizziness, Weak, Diaphoresis, Fever  
| PT Found        | Ambulatory, in bathroom  
| Medical Hx      | High cholesterol, stroke/CVA  
| Medications     | Aspirin  
| Allergies       | NKDA  
| Impression      | General illness

**Narrative**

Unit 1 arrived on scene to find pt. in rear bathroom, unsteady on feet, appearing flushed and diaphoretic. Pt. appears to be struggling to walk, and is holding wall for support. Pt. notes he just vomited for 4th time in past hour. Pt. had acute onset of symptoms (noted above) while in bed. Wife called EMS because of concern over excessive temperature (102.5, as per wife), vomiting and sweating. EKG monitor applied to rule out any cardiac problems in light of nausea/vomiting and elevated temp. Pt. complains of nausea that has not been relieved by vomiting. Despite fever and clammy skin, pt. denies feeling cold. Pt. denies chest pain, or difficulty breathing. Pt. denies food allergies, or eating any unusual foods. Pt. assisted back to bed while EMS crew obtained stretcher from rig. Pt. assisted to stretcher via stand and pivot, with assistance by crewmembers on both sides, for support. Pt. given emesis bag during transport, and he vomited once enroute - clear fluids approximately 250 mL. Patient transported to Community Hospital without incident.

Assessment: Skin: Diaphoretic, Cold; Head: Normal; Neck: Normal; Chest/Lungs: Normal; Heart: Normal; Abdomen: Normal; Back: Normal; Upper extremities: Normal; Lower Extremities: Normal; Mental Status: A&Ox4

**OPQRST:** Onset: 7/31/16 03:30; Provocation: None; Quality: none; Radiation: None; Severity: 0; Time: None

**Treatment Log**

<table>
<thead>
<tr>
<th>Time</th>
<th>B/P</th>
<th>HR</th>
<th>RR</th>
<th>SPO2</th>
<th>ETCO2</th>
<th>Temp</th>
<th>Exam (Neuro, RR, CV, ABD, Skin)</th>
<th>Treatment (O2, MED, PIV, Extrication)</th>
</tr>
</thead>
<tbody>
<tr>
<td>04:43:41</td>
<td>151/80</td>
<td>66</td>
<td>14</td>
<td></td>
<td></td>
<td>97%</td>
<td>BGL=130; 3-lead EKG = NSR</td>
<td>Ondansetron 4 mg SL</td>
</tr>
<tr>
<td>04:52:45</td>
<td>127/80</td>
<td>54</td>
<td>14</td>
<td>97%</td>
<td></td>
<td></td>
<td>GCS= 6/5/4</td>
<td>IV 20 g, left hand, 1000 ml for fluid replacement</td>
</tr>
<tr>
<td>04:55:01</td>
<td>148/82</td>
<td>54</td>
<td>14</td>
<td>97%</td>
<td></td>
<td></td>
<td>12-lead EKG = Sinus Brady</td>
<td>Ondansetron 4 mg SL</td>
</tr>
</tbody>
</table>

**Crew Information**

| Lead       | Peter Pan  
| Cert#      | P-00755  
| Level      | P  
| Signature  | Peter Pan  

| Driver     | Tinker Bell  
| Cert#      | P-00377  
| Level      | P  
| Signature  | Tinker Bell  

---

**Notes:**

- Ambulance: Mickey Mouse
- Patient: Hank Septopus
- Date: 7/31/16
Mickey Mouse Ambulance Signature/Claim Submission Authorization Form

**Patient Name:** Hank Septopus  
**Transport Date:** 10/4/12

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

---

**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 authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mickey Mouse Ambulance now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Mickey Mouse Ambulance, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Mickey Mouse Ambulance any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Mickey Mouse Ambulance. I authorize Mickey Mouse Ambulance 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 Mickey Mouse Ambulance 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 Mickey Mouse Ambulance, now, in the past, or in the future. I also authorize Mickey Mouse Ambulance to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

**If the patient signs with an “X” or other mark, a witness should sign below.**

**Patient Signature or Mark**  
**Date**  
**Witness Signature**  
**Date**

---

**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 Mickey Mouse Ambulance now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

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 services) but furnished other care, services, or assistance to the patient

**Representative Signature**  
**Date**  
**Printed Name and Title of Representative**

---

**SECTION III - AMBULANCE 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 Mickey Mouse Ambulance.

**A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)**

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

**Signature of Crewmember**  
**Date**  
**Printed Name and Title of 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 furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

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

---

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.
Client: Mickey Mouse Ambulance

Trip ID #: 102 E

Patient: Hank Septopus

Date of Service: 7/31/16

From: 21637 Augusta Dr., Zootopia 99918

To: 6467 Race St., Zootopia, 99918

Loaded Miles: 1.5

Directions Plotted: 8/7/16 07:59

Source: Mileage calculated from Mapquest on Import

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Distance</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depart 21637 Augusta Dr. towards Golf View Rd.</td>
<td>0.1</td>
<td>Miles</td>
</tr>
<tr>
<td>Turn Right onto Golf View Rd.</td>
<td>0.1</td>
<td>Miles</td>
</tr>
<tr>
<td>Take ramp onto HWY 283 E</td>
<td>0.1</td>
<td>Miles</td>
</tr>
<tr>
<td>Take Exit 13, on Right</td>
<td>1.0</td>
<td>Miles</td>
</tr>
<tr>
<td>Turn left onto Race St.</td>
<td>0.1</td>
<td>Miles</td>
</tr>
<tr>
<td>Destination on Right</td>
<td>0.1</td>
<td>Miles</td>
</tr>
</tbody>
</table>
Run 103-E
Mickey Mouse Ambulance

Patient Care Report

RUN NUMBER: 103E

PATIENT NAME: Yzma Eveel

DATE OF SERVICE: 9/24/16

Times | Response Information | Mileage
---|---|---
CALL RECV'D: 20:35:54 | DISPATCH CODE: 001 - Cardiac | TO SCENE
DISPATCH: 20:36:12 | RESPONSE PRIORITY: Delta | ON SCENE: 561.7
ENROUTE: 20:38:50 | LOCATION: Golden SNF 2319 Sock Dr., Monstropolis, 99917 | ENROUTE TO DEST.: 561.7
ON SCENE: 20:41:12 | TRANSPORTED TO: Good Samaritan Hospital, 14 Randall Dr., Monstropolis 99917 | AT DEST.: 567.8
DEPART SCENE: 21:04:32 | TRANSPORT PRIORITY: Delta | TOTAL LOADED MILEAGE: 6.1
ARRIVE DEST.: 21:16:15 | DISPATCH COMMENTS: Pt. called direct from SNF – states chest pain

Demographic

NAME: Yzma Eveel
DOB: 7/16/1941
AGE: 74
WEIGHT: 127
ADDRESS: 230 South Clark Rd., Radiator Springs 99912
SEX: F

Initial Information

CHIEF COMPLAINT: “I want to have a BM”
MEDICAL HX: HBP, Diabetes, Thyroid Disorder, Anxiety, Bipolar, Depression, Schizophrenia, Dementia
ALLERGIES: Aspirin
MEDICATIONS: Reglan, Colace, Brilinta, Megestrol, Miraiax, Coreg, Protonix, Simvastatin, Glipizide

Assessment: Skin: Warm, Dry; Head/Face: Normal; Neck: Normal; Chest/Lungs: Normal Breath Sounds: Heart: Not Done; Back: Normal; Upper Extremities: Normal; Lower extremities: Normal

Narrative

Unit 2 responded to above location (SNF) for report of possible heart attack. Crew met at door by nursing staff who led us to pt. room where 74 yof was found lying on bed, A&Ox4, able to answer all questions appropriately, but slowly. Pt. appeared to be extremely tired, and couldn’t keep her eyes open. Pt. was not in respiratory distress and complained of having to have a bowel movement and general weakness x 1 hour. Pt. states “I need to have a BM but nurses all ignore me, so I called for you to take care of me.” Pt. has history of dementia and bipolar disorder. During assessment and initial base-line vitals, pt. reports that her chest hurts, and that it “comes and goes.” Both 4-lead and 12-lead EKG show NSR. BP was 88/40 and d-stick was 200. Pt. had very poor skin turgor and appeared dehydrated. Pt. denied back, neck abdominal pains, or SOB. Nursing staff reports pt. had been acting normal for past 12-18 hours. Pt. frequently falls asleep and we need to awake her to continue assessment. IV established in left hand for administration of IV fluids. After several minutes, BP was observed to reach acceptable level, after about 400 cc of fluid. Family member on scene (who was called to SNF after 911 was initiated) consented to transport to hospital and signed on behalf of patient. Pt. condition was closely monitored while enroute. Pt. delivered to ER room 10 and report given to RN. Pt. condition did improve while under EMS care.

Symptoms: General: Weakness, Thirst; Cardiovascular: Chest Pain/Angina; Metabolic: Hyperglycemia; Respiratory: None; Neurological: None; Musculoskeletal: none
Assessment: Skin: Warm, Dry; Head/Face: Normal; Neck: Normal; Chest/Lungs: Normal Breath Sounds: Heart: Not Done; Back: Normal; Upper Extremities: Normal; Lower extremities: Normal

Treatment Log

<table>
<thead>
<tr>
<th>TIME</th>
<th>B/P</th>
<th>HR</th>
<th>RR</th>
<th>SPO2 ETCO2</th>
<th>TEMP</th>
<th>EXAM (NEURO, RR, CV, ABD, SKIN)</th>
<th>TREATMENT (O2, MED, PIV, EXTRICATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20:43:24</td>
<td>88/40</td>
<td>92</td>
<td>14</td>
<td>99%</td>
<td>98.2</td>
<td>BGL = 200; No obvious signs of trauma; ALS assessment</td>
<td>IV Left hand 22 gauge 500 mL NSS TKO</td>
</tr>
<tr>
<td>20:47:15</td>
<td>98/44</td>
<td>87</td>
<td>16</td>
<td>100%</td>
<td>EKG = NSR</td>
<td>EKG = NSR</td>
<td></td>
</tr>
<tr>
<td>20:58:34</td>
<td>90/50</td>
<td>90</td>
<td>16</td>
<td>98%</td>
<td>EKG = NSR</td>
<td>EKG = NSR</td>
<td></td>
</tr>
<tr>
<td>21:15:02</td>
<td>103/54</td>
<td>90</td>
<td>16</td>
<td>96%</td>
<td>EKG = NSR</td>
<td>Saline lock right hand 22 gauge</td>
<td></td>
</tr>
</tbody>
</table>

Crew Information

<table>
<thead>
<tr>
<th>Lead</th>
<th>Donald Duck</th>
<th>CERT#</th>
<th>P-00031</th>
<th>LEVEL</th>
<th>P</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver</td>
<td>Daisy Duck</td>
<td>CERT#</td>
<td>B-00014</td>
<td>LEVEL</td>
<td>B</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>

Donald Duck
Daisy Duck
Mickey Mouse Ambulance Signature/Claim Submission Authorization Form

Patient Name: Yzma Eveel  Transport Date: 9/24/16

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

<table>
<thead>
<tr>
<th>SECTION I - PATIENT SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient must sign here unless the patient is physically or mentally incapable of signing.</td>
</tr>
<tr>
<td>NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.</td>
</tr>
<tr>
<td>I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mickey Mouse Ambulance now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Mickey Mouse Ambulance, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Mickey Mouse Ambulance any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Mickey Mouse Ambulance. I authorize Mickey Mouse Ambulance 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 Mickey Mouse Ambulance 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 Mickey Mouse Ambulance, now, in the past, or in the future. I also authorize Mickey Mouse Ambulance to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.</td>
</tr>
<tr>
<td>If the patient signs with an “X” or other mark, a witness should sign below.</td>
</tr>
<tr>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete this section only if the patient is physically or mentally incapable of signing.</td>
</tr>
<tr>
<td><strong>Describe the circumstances that make it impractical for the patient to sign:</strong> Dementia history</td>
</tr>
<tr>
<td>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 Mickey Mouse Ambulance now, in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. <strong>My signature is not an acceptance of financial responsibility for the services rendered.</strong></td>
</tr>
<tr>
<td>Authorized representatives include only the following individuals:</td>
</tr>
<tr>
<td>□ Patient’s legal guardian</td>
</tr>
<tr>
<td>□ Relative or other person who receives social security or other governmental benefits on behalf of the patient</td>
</tr>
<tr>
<td>□ Relative or other person who arranges for the patient’s treatment or exercises other responsibility for the patient’s affairs</td>
</tr>
<tr>
<td>□ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>Representative Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Describe the circumstances that make it impractical for the patient to sign:</strong></td>
</tr>
<tr>
<td>Name and Location of Receiving Facility: ______________________</td>
</tr>
<tr>
<td>A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)</td>
</tr>
<tr>
<td>My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. <strong>My signature is not an acceptance of financial responsibility for the services rendered.</strong></td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>B. Receiving Facility Representative Signature</td>
</tr>
<tr>
<td>The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. <strong>My signature is not an acceptance of financial responsibility for the services rendered.</strong></td>
</tr>
<tr>
<td>X</td>
</tr>
</tbody>
</table>

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.
Unit 4 dispatched to above location for reported headache. AOS to find 97 yof lying in bed conscious and alert to person and place complaining of weakness and fatigue. Pt. reports symptoms have occurred for past 2 days. Pt. son also reports pt. has been complaining of a headache and blurred/decreased vision in left eye (right eye is blind from prior traumatic injury). Pt. son reports pt. has not seen a physician in over 20 years. Full BLS assessment performed by Hans Southern. EMT called for Paramedic back-up for ALS interventions to be performed. Happy Dwarf responded in ALS flycar and performed further ALS assessment, and interventions as noted below. Happy Dwarf accompanied patient and Kristoff Anderson drove ambulance to hospital, while Hans Southern drove flycar. Pt. noted she was unwilling to sign because of severe headache and inability to see form. Patient son unwilling to sign on behalf of patient.

Assessment: Skin: Normal; Head: Normal; Chest/Lungs: Normal; Heart: Normal; Abdomen: Normal; Back: Normal; Upper Extremities: Normal; Lower Extremities: Normal; Left Eye: Reactive; Right Eye: Blind/not assessed; Mental Status: Oriented x 2 (Person/Place); Cincinnati Stroke Scale: Negative

Injury: Headache – Onset: 48 hours; Provocation: Light; Quality: Sharp; Radiation: None; Severity: 8/10; Time: Constant

Interventions: 20 gauge IV established with 250 mL NSS TKO and for fluid replacement for possible dehydration. EKG established as precaution due to pt. age and complaint of severe weakness. Due to decreased SpO2 levels, O2 was applied.
**Mickey Mouse Ambulance Signature/Claim Submission Authorization Form**

**Patient Name:** Bailey Seen  
**Transport Date:** 9/25/16

**Privacy Practices Acknowledgment:** by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

---

### 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 authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Mickey Mouse Ambulance** now, in the past, or in the future.  

I agree to immediately remit to **Mickey Mouse Ambulance** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **Mickey Mouse Ambulance**.  

I authorize **Mickey Mouse Ambulance** to appeal payment denials or other adverse decisions on my behalf.  

**My signature is not an acceptance of financial responsibility for the services rendered.**

*If the patient signs with an "X" or other mark, a witness should sign below.*

<table>
<thead>
<tr>
<th>Patient Signature or Mark</th>
<th>Date</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:**  

- unwilling

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 **Mickey Mouse Ambulance** now or in the past or in the future.  

By signing below, I acknowledge that I am one of the authorized signers listed below.  

**My signature is not an acceptance of financial responsibility for the services rendered.**

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 services) but furnished other care, services, or assistance to the patient

<table>
<thead>
<tr>
<th>Representative Signature</th>
<th>Date</th>
<th>Printed Name and Title of Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td>Kristoff Anderson, EMT</td>
</tr>
</tbody>
</table>

### SECTION III - AMBULANCE 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:**  

- unwilling to sign, blind, vision problems

**Name and Location of Receiving Facility:** General Hospital  
**Time:** 14:15

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Mickey Mouse Ambulance**.

**Ambulance Crew Member Statement (must be completed by crew member at time of transport)**

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

**My signature is not an acceptance of financial responsibility for the services rendered.**

<table>
<thead>
<tr>
<th>Signature of Crewmember</th>
<th>Date</th>
<th>Printed Name and Title of Crewmember</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Kristoff Anderson</td>
<td>14:20</td>
<td>Kristoff Anderson, EMT</td>
</tr>
</tbody>
</table>

**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 furnished care, services or assistance to the patient.  

**My signature is not an acceptance of financial responsibility for the services rendered.**

<table>
<thead>
<tr>
<th>Signature of Receiving Facility Representative</th>
<th>Date</th>
<th>Printed Name and Title of Receiving Facility Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.
<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th>Bailey Seen</th>
<th><strong>DOB:</strong></th>
<th>03/10/1919</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADDRESS:</strong></td>
<td>602 Coral Way, Atlantica, 99914</td>
<td><strong>PHONE NUMBER:</strong></td>
<td>(XXX)XXX- 5763</td>
</tr>
<tr>
<td><strong>NEXT OF KIN:</strong></td>
<td>Lucas Seen (Son)</td>
<td><strong>NEXT OF KIN PHONE NUMBER:</strong></td>
<td>(XXX)XXX- 0956</td>
</tr>
<tr>
<td><strong>INSURANCE INFORMATION 1:</strong></td>
<td>Medicare</td>
<td><strong>INSURANCE INFORMATION 2:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATE OF ADMISSION:</strong></td>
<td>09/25/2016</td>
<td><strong>DATE OF DISCHARGE:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL HISTORY:</strong></td>
<td>Dementia, eye problems</td>
<td><strong>MEDICATIONS:</strong></td>
<td>Clopidogrel, Gabapentin, Haloperidol, Lamsoprazole, Primidone, Sertaline</td>
</tr>
</tbody>
</table>

**NOTES**

Arrived at ED via Mickey Mouse Ambulance at 14:15
Run 105-E
**Mickey Mouse Ambulance**

**Patient Care Report**

**RUN NUMBER:** 105 E  
**PATIENT NAME:** Hiram Flaversham  
**DATE OF SERVICE:** 8/22/16

### Times | Response Information | Mileage
--- | --- | ---
**CALL RECVD** | 11:40:10 |  
**DISPATCH** | 11:41:04 |  
**ENROUTE** | 11:42:56 |  
**ON SCENE** | 11:44:19 |  
**DEPART SCENE** |  |  
**ARRIVE DEST.** |  |  

### DISPATCH CODE 
026 Syncope/Vertigo BLS  
**TO SCENE**  
**ON SCENE**  
**ENROUTE TO DEST.**  
**AT DEST.**  
**TOTAL LOADED MILEAGE**

### Demographic
- **NAME:** Hiram Flaversham  
- **DOB:** 1/28/1944  
- **AGE:** 72  
- **WEIGHT:** 91 kg  
- **ADDRESS:**  
- **SEX:** M

### Initial Information
- **CHIEF COMPLAINT:** Ground level fall  
- **PT FOUND:** Lying on ground  
- **MEDICAL HX:** Angina, HTN, Depression, Insomnia  
- **MEDICATIONS:** Lithium, Trazodone, Mirtazapine, Klonopin, Paroxetine, Ativan, Folic Acid  
- **ALLERGIES:** Unknown  
- **IMPRESSION:**

### Narrative
Unit 3 dispatched 911 to above location for report of ground level fall with minor injuries. Upon arrival, crew found 72 yom with known history of ETOH abuse, psych conditions, and depression who sustained a ground level fall outside Urgent Care Clinic. Pt. reports he was sick for past few days with nausea/vomiting, and gout exacerbation in both feet. Pt. reports he has seen Doc Dwarf at the Urgent Care Clinic several times over the past few weeks, and had been prescribed two medications for gout, but was unable to fill due to cost. Pt. states he was coming to Urgent Care Clinic due to unrelenting pain and difficulty ambulating due to gout symptoms. While walking in the front door, pt. stumbled and fell to ground. He believes he fell and tripped over door mat, but witnesses state that he appeared unsteady on his feet even before he approached the door. Witnesses also report that as he approached the automatic door, he grabbed at it as he began to fall. Immediately after the event, Urgent Care Center personnel came to his aid, with Doc Dwarf reporting the patient appeared "stiff and out of it," believing the patient may have sustained a seizure. Urgent Care Center staff called 911 as a result. Pt. exhibits good mentation and answers questions appropriately, with strong odor of ETOH present. Pt. admits to drinking a pint of alcohol prior to the event, and admits to normally drinking at least 2 pints of ETOH each day. Pt. denies pain to head, neck, or back. Pupils appear equal and reactive to light. Breath sounds are clear bilaterally. Abdomen appears normal and mildly tender to palpation. Pelvis appears stable, and pt. is able to spontaneously move all extremities. No facial asymmetry, dysphasia, or focal weakness noted. No obvious trauma detected, and no indication of extremity tremors or incontinence. Pt. was assisted to foot of gout exacerbation, where pt. exhibited 10-point increase in heart rate, without orthostatic hypotension or dizziness. Patient assisted to waiting room at Urgent Care Clinic, where he stated he "only wants to be seen here." EMS consulted with Doc Dwarf and pt. spouse, Olivia Haversham about pt. request to be seen at clinic and not transported. Doc Dwarf agreed to see patient. Patient spouse and POA signed AMA/Refusal form and no further intervention was provided by EMS.

### Treatment Log

<table>
<thead>
<tr>
<th>TIME</th>
<th>B/P</th>
<th>HR</th>
<th>RR</th>
<th>SPO2</th>
<th>ETCO2</th>
<th>TEMP</th>
<th>EXAM (NEURO, RR, CV, ABD, SKIN)</th>
<th>TREATMENT (O2, MED, PIV, EXTRICATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:49</td>
<td>132/88</td>
<td>90</td>
<td>14</td>
<td>96%</td>
<td>80%</td>
<td>96°F</td>
<td>GCS = 4/5/6</td>
<td>Note: laying BP/pulse</td>
</tr>
<tr>
<td>11:52</td>
<td>138/94</td>
<td>100</td>
<td>14</td>
<td>95%</td>
<td>75%</td>
<td>95°F</td>
<td>GCS = 4/5/6</td>
<td>Note: standing BP/pulse</td>
</tr>
</tbody>
</table>

### Crew Information
- **Lead:** Flounder Ing  
  - CERT#: B-00046  
  - LEVEL: B  
  - SIGNATURE: Flounder Ing
- **Driver:** Sebastian Mon  
  - CERT#: P-00823  
  - LEVEL: P  
  - SIGNATURE: Sebastian Mon
Mickey Mouse Ambulance Refusal Form

Patient Name:  Hiram Flaversham        Date:   8/22/16  Run #: 105 E

This form is being provided to me because I have: (check all that apply)

☐ REFUSED ASSESSMENT     ☐ REFUSED TREATMENT     ☒ REFUSED TRANSPORT

☐ INSISTED ON BEING TRANSPORTED TO A HOSPITAL OTHER THAN THAT WHICH THE EMS PERSONNEL RECOMMEND

I understand that the EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand and have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room may lack the staff, equipment, beds or resources to care for me promptly, and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by the ambulance crew and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless the ambulance service and its officers, members, employees or other agents, and the medical command physician and medical command facility, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the ambulance service or its crew, or the medical command physician or medical command facility.

I also acknowledge receipt of the ambulance service’s Notice of Privacy Practices.

OTHER SPECIFIC INSTRUCTIONS TO PATIENT:     Call 911 to request transport if you change your mind.

Olivia Flaversham, Health Care/Medical POA 8/22/16

Signature of:  Patient ☐        Parent ☐        Legal Guardian ☒ Date

Flounder Ing, EMTB

Witness Signature

IF PATIENT REFUSES TO SIGN: I attest that the patient has refused care and/or transportation by the emergency medical services providers. The patient was informed of the risks of this refusal and refused to sign this form when asked by the EMS providers.

Witness Signature        Print Name
Run 106-E
**Mickey Mouse Ambulance**

**Patient Care Report**

**RUN NUMBER:** 106 E  
**PATIENT NAME:** Spot Caveboy  
**DATE OF SERVICE:** 9/5/16

### Times and Response Information

<table>
<thead>
<tr>
<th>Time</th>
<th>Action</th>
<th>Code/Data</th>
<th>Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td>23:12:38</td>
<td>CALL REC'D (9/5/16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:13:03</td>
<td>DISPATCH</td>
<td>002 Respiratory ALS</td>
<td>TO SCENE</td>
</tr>
<tr>
<td>23:14:12</td>
<td>ENROUTE</td>
<td>Freestanding Clinic, Highway 15 North, Frontierland 99913</td>
<td>ENROUTE TO DEST. 5672.9</td>
</tr>
<tr>
<td>23:21:45</td>
<td>ON SCENE</td>
<td>Holy Spirit Hospital, 100 14th St. Radiator Springs, 99912</td>
<td>AT DEST. 5682.0</td>
</tr>
<tr>
<td>23:55:00</td>
<td>DEPART SCENE</td>
<td>Delta</td>
<td>TOTAL LOADED MILEAGE 9.1</td>
</tr>
<tr>
<td>00:10:10</td>
<td>ARRIVE DEST. (9/6/16)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mileage

- **Total Loaded Mileage:** 9.1

### Dispatch Comments

Pt. in parking lot of facility, which is closed

### Demographic

- **NAME:** Spot Caveboy  
- **DOB:** 1/7/1943  
- **AGE:** 73  
- **WEIGHT:** 176  
- **ADDRESS:** 98 Rolling Ave. Animal Kingdom  
- **SEX:** M

### Initial Information

- **CHIEF COMPLAINT:** Pt. is sick
- **PT FOUND:** Lying in back seat of car
- **MEDICAL HX:** CHF, A-fib, hypertension, diabetes  
- **MEDICATIONS:** Diltiazem, Lyrica, Warfarin, Digoxin, Tramadol
- **ALLERGIES:** NKDA  
- **IMPRESSION:** Cardiac

### Narrative

Unit 1 dispatched Delta for report of respiratory problem. Pt. Spanish speaking only and his son is translating, but he speaks minimal English, making communication difficult. As per son, pt. complains of nausea, which started 1 hour prior. Son reports that he was trying to take pt. to the freestanding ED/clinic to be seen, but it was closed – he then called 911 from parking lot of the facility. Son states they drove from the neighboring state, Animal Kingdom. Physical assessment performed:

- **Airway:** Clear;  
- **Breathing:** Normal;  
- **Circulation:** Normal;  
- **CRT:** 5 seconds;  
- **Skin:** Pale;  
- **Neuro AVPU:** A&Ox4;  
- **Neuro Motor:** Moves all extremities;  
- **Eyes:** PEARL;  
- **EKG:** Sinus Brady (40 bpm), with hypotension (76/PALP).

Pt. denies chest pain, but due to bradycardia, age, and nausea, pt. treated under cardiac protocol. Pt. given 324 mg ASA and IV established in left hand. Medical command notified, which advised no nitro, but to perform cardiac pacing at 60 BPM 80mV for low HR and low BP. Cardiac pacing performed with LifePack. Pacing continued during transport, with gradual improvement to BP and HR (as below). Pt. transported to Holy Spirit Hospital without incident. Transfer of care provided to RN Clara Belle at ED.

I accept this patient: Clara Belle, RN

### Treatment Log

<table>
<thead>
<tr>
<th>Time</th>
<th>B/P</th>
<th>HR</th>
<th>RR</th>
<th>SPO2</th>
<th>TEMPERATURE</th>
<th>Exam (NEURO, RR, CV, ABD, SKIN)</th>
<th>Treatment (O2, MED, PIV, EXTRICATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>23:24:38</td>
<td>76/PALP</td>
<td>40</td>
<td>16</td>
<td>98%</td>
<td>96.7</td>
<td>12-lead EKG = Sinus Brady</td>
<td>IV 22 G, ASA (324 mg)</td>
</tr>
<tr>
<td>23:30:35</td>
<td>194/98</td>
<td>60</td>
<td>16</td>
<td>96%</td>
<td>GCS=15 (6/5/4)</td>
<td></td>
<td>IV Med – Atropine (0.5 mg) Cardiac pacing</td>
</tr>
<tr>
<td>23:40:28</td>
<td>175/86</td>
<td>60</td>
<td>16</td>
<td>98%</td>
<td>BGL = 86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:57:10</td>
<td>160/80</td>
<td>60</td>
<td>16</td>
<td>98%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Crew Information

- **Lead:** Tinker Bell  
  - **CERT#:** P-00377  
  - **LEVEL:** P  
  - **SIGNATURE:** Tinker Bell
- **Driver:** Peter Pan  
  - **CERT#:** P-00755  
  - **LEVEL:** P  
  - **SIGNATURE:** Peter Pan
Mickey Mouse Ambulance Signature/Claim Submission Authorization Form

Patient Name: Spot Caveboy
Transport Date: 9/5/16

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

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 authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mickey Mouse Ambulance now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Mickey Mouse Ambulance, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Mickey Mouse Ambulance any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Mickey Mouse Ambulance. I authorize Mickey Mouse Ambulance 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 Mickey Mouse Ambulance 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 Mickey Mouse Ambulance, now, in the past, or in the future. I also authorize Mickey Mouse Ambulance to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an “X” or other mark, a witness should sign below.

X
Patient Signature or Mark Date Witness Signature Date

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

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 Mickey Mouse Ambulance now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

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 services) but furnished other care, services, or assistance to the patient

X
Representative Signature Date Printed Name and Title of Representative

SECTION III - AMBULANCE 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: ________________________________

Language barrier, Spanish speaking only. Son is not well versed in English language.

Name and Location of Receiving Facility: Holy Spirit Hospital
Time: 00:15:00

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Mickey Mouse Ambulance.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient’s behalf. My signature is not an acceptance of financial responsibility for the services rendered.

X Peter Pan 9/6/16 Peter Pan
Signature of Crewmember Date Printed Name and Title of 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 furnished care, services or assistance to the patient. My signature is not an acceptance of financial responsibility for the services rendered.

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

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.
**Mickey Mouse Ambulance**

### Patient Care Report

**RUN NUMBER:** 107 E  
**PATIENT NAME:** Riley Anderson  
**DATE OF SERVICE:** 10/3/2016

<table>
<thead>
<tr>
<th>Times</th>
<th>Response Information</th>
<th>Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL RECV'D</td>
<td>05:10:12</td>
<td></td>
</tr>
<tr>
<td>DISPATCH</td>
<td>05:15:12</td>
<td></td>
</tr>
<tr>
<td>ENROUTE</td>
<td>05:15:56</td>
<td></td>
</tr>
<tr>
<td>ON SCENE</td>
<td>05:19:36</td>
<td></td>
</tr>
<tr>
<td>DEPART SCENE</td>
<td>05:34:34</td>
<td></td>
</tr>
<tr>
<td>ARRIVE DEST.</td>
<td>05:37:34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DISPATCH COMMENTS:</td>
<td>3 police officers around patient's bed – pt. in handcuffs – combative still</td>
</tr>
</tbody>
</table>

| Demographic | | |
|-------------|--|--|---|
| NAME        | Riley Anderson | DOB | 11/18/1935 | AGE | 80 | WEIGHT |
| ADDRESS     | 1804 Forest Hill Rd., Zootopia, 99918 | SEX | F |

<table>
<thead>
<tr>
<th>Initial Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIEF COMPLAINT</td>
<td>Psychiatric Problems</td>
<td>PT FOUND</td>
</tr>
<tr>
<td>MEDICAL HX</td>
<td>Anemia, Anxiety, CKD, Dementia, Depression, DM, Encephalopathy, HTN</td>
<td>MEDICATIONS ASa, Glipizide, Iron, KCl, Lasix, Lisonopril, Metaprolol, Risperdal, Trazadone</td>
</tr>
<tr>
<td>ALLERGIES</td>
<td>None</td>
<td>IMPRESSION</td>
</tr>
</tbody>
</table>

**Narrative**

Exam: Airway: Patent; Respiratory: Normal, Equal, clear lung sounds; Cardiovascular: JVD: Not appreciated; Cap. Refill: Less than 2 seconds; Edema: Not appreciated; Neuro: Level of consciousness: Agitated; Loss of Consciousness: No; Chemically Paralyzed: No; Mental Present: Combative, Oriented to Person Only; ALS Assessment: Not required; Pupils: PEARL: Motor Sensory: All extremities normal. Head: Unremarkable; Neck: Supple, Trachea midline; Chest: Wall intact, clear bilateral breath sounds; Abdominal appearance: Normal; Pelvis: Stable to flex/compression; Skin: Warm and dry.

Unit 6 dispatched for psych patient at above location. UOA found 80 yof A&Ox1 (person) alert to normal status per facility staff, who reports this is a new admit who has been "acting out" since arrival. Per facility staff, this a.m. pt. attempted to assault staff members, and DON at facility advised staff to send pt. to hospital for eval. Pt. is very combative, refusing vitals, but appeared to be hemodynamically stable. Pt. loaded to stretcher and placed in rig with Police Officers on board. Soft wrist and ankle restraints were applied to protect patient and crew. Pt. transports routine ("Alpha") to Community Hospital (closest appropriate location). No changes in status noted enroute. Pt. was combative when intervention /skill was attempted. Upon arrival at ED, placed in Room 4, with report given to ER RN.

<table>
<thead>
<tr>
<th>Treatment Log</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME</td>
<td>B/P</td>
<td>HR</td>
</tr>
<tr>
<td>05:21</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

| Crew Information | | |
|------------------|--|---|---|
| Lead             | Dopey Dwarf | CERT# | B-00765 | LEVEL | B | SIGNATURE | Dopey Dwarf |
| Driver           | Happy Dwarf | CERT# | P-00978 | LEVEL | P | SIGNATURE | Happy Dwarf |
Mickey Mouse Ambulance Signature/Claim Submission Authorization Form

Patient Name: Riley Anderson  Transport Date: 10/3/16

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Mickey Mouse Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

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 authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mickey Mouse Ambulance now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Mickey Mouse Ambulance, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Mickey Mouse Ambulance any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Mickey Mouse Ambulance. I authorize Mickey Mouse Ambulance 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 Mickey Mouse Ambulance 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 Mickey Mouse Ambulance, now, in the past, or in the future. I also authorize Mickey Mouse Ambulance to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an “X” or other mark, a witness should sign below.

X ____________________________________ Date ________________
Patient Signature or Mark

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE
Describe the circumstances that make it impractical for the patient to sign: AMS, restrained

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 Mickey Mouse Ambulance now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

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 services) but furnished other care, services, or assistance to the patient

X Minnie Mouse, RN
__________________________________ Date ________________
Representative Signature

Printed Name and Title of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES
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: ______________________________

Name and Location of Receiving Facility: ____________________________

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Mickey Mouse Ambulance.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on behalf of the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

X ____________________________________ Date ________________
Signature of Crewmember

Printed Name and Title of 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 furnished care, services or assistance to the patient. My signature is not an acceptance of financial responsibility for the services rendered.

X ____________________________________ Date ________________
Signature of Receiving Facility Representative

Printed Name and Title of Receiving Facility Representative

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.