INTERCITY AMBULANCER FOR EMGERCENCY MEDICAL REPORT

PATIENT CARE REPORT

DISPATCH

Total Milleage: 1000 miles	**Date:** 5/10/2019	**Run Id:** 01052019	**Veh. Id:** 431
Agency Name: Intercity Ambulance	**Location:** 4338	**L.code:** 78202	**Dispatch Info:** Dispatch Info TestTo
L. Type Residence		**Cross Street:** 433 Savannah Dr	
Call Received: 21:32	**On Route:** 21:32	**At Scene:** 21:32	**From Scene:** 21:32
At Destination: 21:32	**In Serrvice:** 21:32	**In Quarter:** 21:32	
Call Type: Hospital Transfer	**Patient Number:** 3	**Dispatch Method: 911**	

DEMOGRAPHIC

First Name: Long	**Middle Name:** Thien	**Last Name:** Hoang	**DOB:** 03/12/1997
Address: 435 Savannah Dr	**APT/Unit:**	**Phone#1:** 2106252293	**Phone#2:**
City: San Antonio	**State:** TX	**Zip:** 78213	**Age:** 21
Gender: Male	**SS#:** 633-48-0143	**Emergency Contact:** Noone	**Emergency Phone:** 210-625-2293

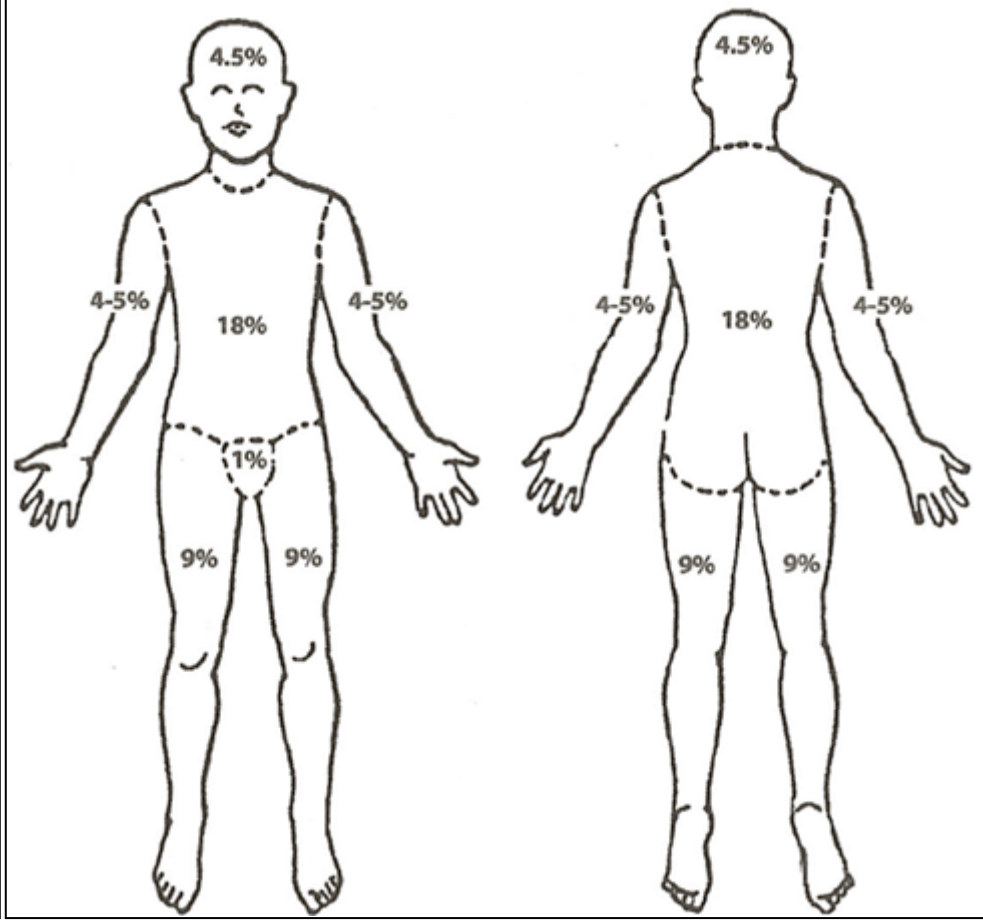
Insurance Information

Primary Insurance Policy:			
Company:		Address:	
Phone:		Group#:	
Policy:	Policy Holder:	SS#:	DOB:
Medicare#:	Medicaid#:	Claim#:	

Secondary Insurance Policy:			
Company:		Address:	
Phone:		Group#:	
Policy:	Policy Holder:	SS#:	DOB:
Medicare#:	Medicaid#:	Claim#:	

PRESENTING PROBLEM

Chief Complaint - Trauma:	Mechanism of Injury: , ,	Presenting Problem: , ,

Diagnostic:			
Chief Complaint - Medical:	**Past Medical History:**	**Medication:**	
Allergy:	**Other:**		

Vital Time	Respiration	Pulse/BP	Level of Conscousness	Pupils	Skin	Status
Vital time:	Respiration: ()	Pulse: BP:	Level of Conscousness:	Pupils: (Right)/ (Left)	Skin:	Status:

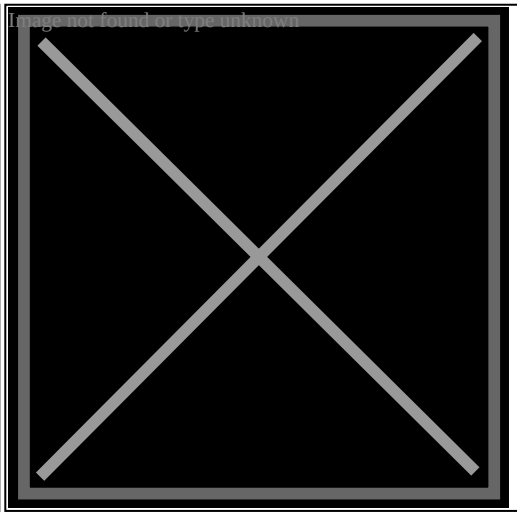
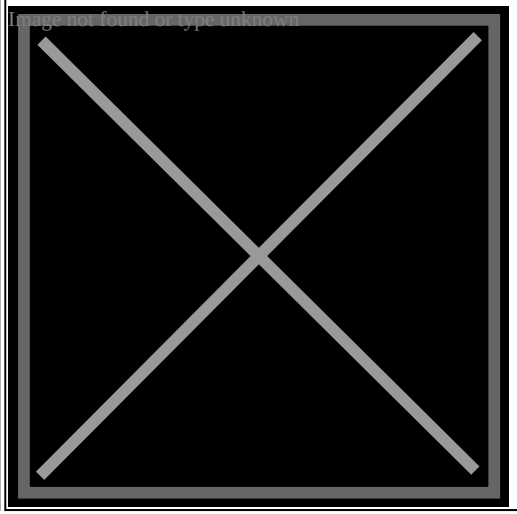
TREATMENT GIVEN

Advanced Life Support (ALS): EndoTracheal Tube (E/T),	**Basic Life Support (BLS)**

DISPOSITION

Not Transported as ALS		**Weight of Patient:** **Purpose of Round Trip:** **Reason for Stretcher:**	
Transportation:			
In Charger: **#:**	**In Charger:** **#:**	**Other:** **#:**	**Other:** **#:**

Narrative Note

Narrative Note:	Image not found or type unknown 
I hereby refuse emergency medical treatment and/or transportation to the nearest emergency medical facility. I acknowledge that such treatment was advised by the ambulance technician or physician. I hereby release such persons from liability for respecting my wishes and following my express directions.	**Patient Signature:** Image not found or type unknown 

AUTHORIZATION

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Senior Care EMS for any

services provided to me by Senior Care now or in the future. I understand that I am financially responsible for the services provided to me by Senior Care MES 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 Senior Care EMS amy 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 Senior Care EMS. I authorize Senior Care EMS to to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Senior Care EMS and its billing agents, and/or the Centers for Medicare andMedicaid 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 Senior Care EMS, now or in the future. A copy of this form is as valid as an original.

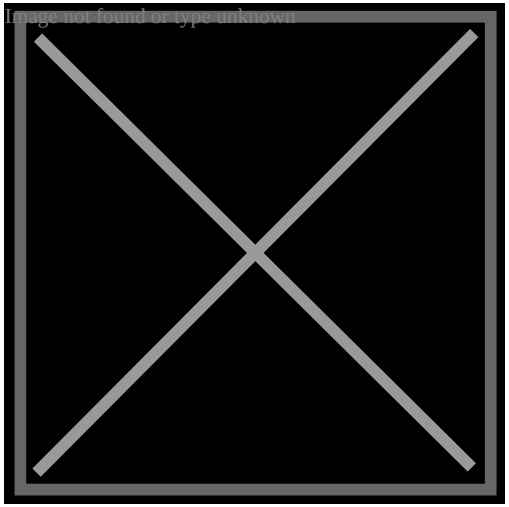
Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received Senior Care EMS Notice of Privacy Practices.

SIGNATURE SECTION: One of the following three sections MUST be completed.

SECTION I - PATIENT SIGNATURE

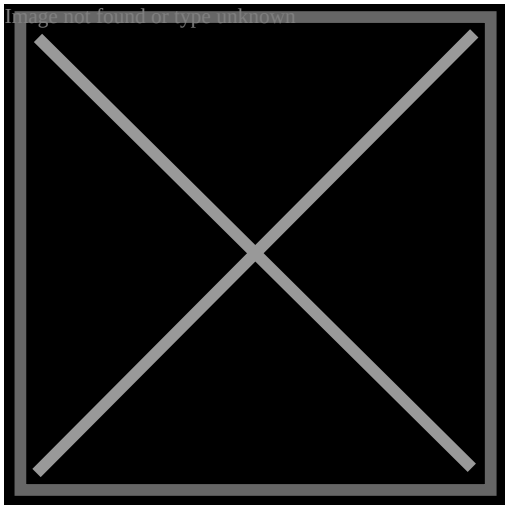
The patient must sign here unless the patient is physically or mentally incapable of signing:

Patient Signature or Mark:



If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness:

Witness Signature:



Witness Printed Name:

If patient is physically or mentally incapable of signing, Section II must be completed.

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

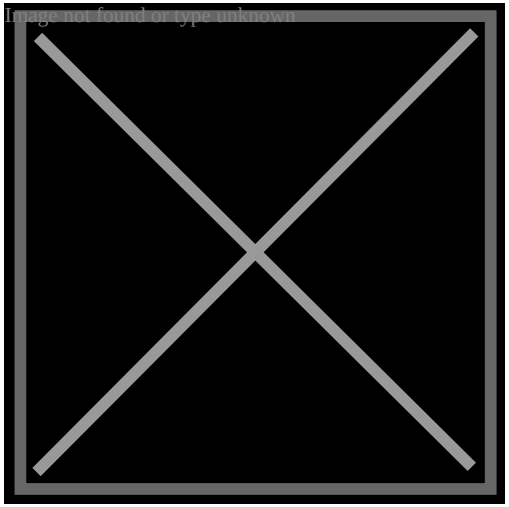
Complete this section only if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

Authorized representatives include only the following individuals:

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

Representative's Signature:



Representatives Printed Name:

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section only for emergency ambulance transports, if patient was physically or mentally incapable of signing, and no authorized representative (as listed in Section II) was available or willing to sign on behalf of the patient at the time of service.

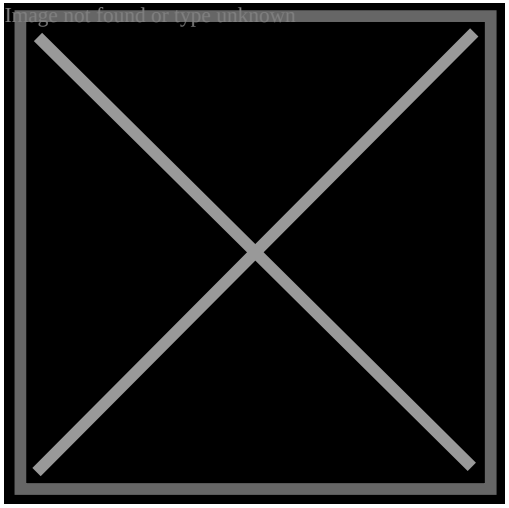
A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above 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.

Reason patient incapable of signing:
Name and Location of Receiving Facility:

Time at Receiving Facility:

Signature of Crewmember:



Printed Name of Crewmember:

B. Receiving Facility Representative Signature

The above-named patient was received by this facility at the date and time indicated above.

Signature of Receiving Facility Representative:

Image not found or type unknown

Printed Name of Receiving Facility Representative:

C. Secondary Documentation

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by Section 164.506(c) of HIPAA.

A.P.C.F

Scheduled Appointment For:

Physicians Certification Statement - Required by 42 CFR 410.40 (D) for all Non-Emergent transports. In my professional opinion, this patient's medical condition requires transport by Ambulance and the level of care that implies and other means of transport are contraindicated based on the patient's health and safety.

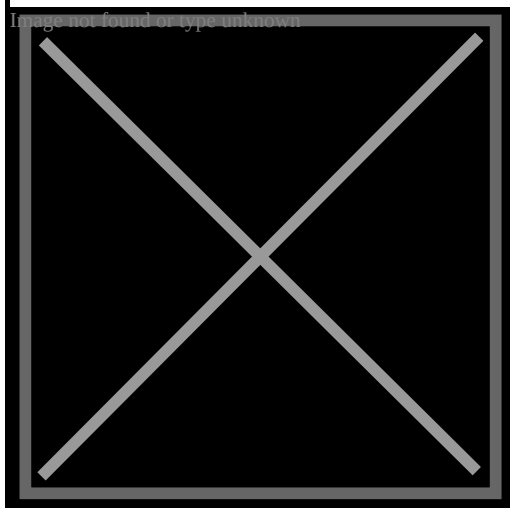
Patient Bed Confined and is Unable to get up or out of bed without assistance AND Unable to ambulate AND Unable to sit in a Wheel chair or chair because: Note: The term applies to individuals who are unable to tolerate any activity out of bed. This term is not synonymous with "Bed Rest", or "Non-Ambulatory", or "Stretcher Bound". All three components must be met in order for the patient to meet the requirements of the definition of "Bed Confined".

Requires an Ambulance because:	**Decubitus Ulcer of:**	**Paralysis:**	**Fracture of:**
Contractures or Abnormal Stiffness or Rigidity of:	**Contractures or Abnormal Stiffness or Rigidity of:**	**Patient Requires Medical Monitoring:**	**Patient Requires Medical Monitoring:**
Other (Describe what or why):			

I certify the above information is true and correct based on my evaluation of this patient. I understand that the information herin shall be used by the Department of Health and Human Services to support the determination of Medical Necessity for Ambulance transportation. This does not guarantee or assure payment shall be made for services rendered to your patient.

Physician or Designee Name: ()

Physician or Designee Signature:



Senior Care Emergency Medical Services Inc EMT Name: