Patient Insurance Form

North Jefferson County Ambulance
3131 Rock Creek Rd.
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Patient Information

Patient's Full Legal Name:: *First* *Middle* *Last*	
Patient's Mailing Address: *Street Number/Name* *City* *State* *Zip*	
Patient's Telephone:	Patient's Email:
Patient's Date of Birth: ___ ___/___ ___/___ ___ ___ ___	Patient's Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___

Primary Insurance Information

Carrier Name:	Insured's Policy/ID/Member #:
Insured's Name:	Group Number:
Insured's Date of Birth: ___ ___/___ ___/___ ___ ___ ___	Insured's Employer:
Relationship to Patient: □ self □ spouse □ parent □ other: ________	Insured's Work Telephone:
What is the claims' address? (Located on the back of your card)	Effective date of Policy: ___ ___/___ ___/ ___ ___
Address:	
City, State, Zip:	Telephone:

Secondary Insurance Information

Carrier Name:	Insured's Policy/ID/Member #:
Insured's Name:	Group Number:
Insured's Date of Birth: ___ ___/___ ___/___ ___ ___ ___	Insured's Employer:
Relationship to Patient: □ self □ spouse □ parent □ other: ________	Insured's Work Telephone:
What is the claims' address? (Located on the back of your card)	Effective date of Policy: ___ ___/___ ___/ ___ ___
Address:	
City, State, Zip:	Telephone:

Other Insurance Information

Injury/illness due to incident at: ☐Work ☐Auto Accident ☐Other:__________________________

Carrier Name:	Insured's Policy/ID/Member #:
Insured's Name:	Group Number:
Insured's Date of Birth: ___ ___/___ ___/___ ___ ___ ___	Insured's Employer:
Relationship to Patient: □ self □ spouse □ parent □ other: ________	Insured's Work Telephone:
What is the claims' address? (Located on the back of your card)	Effective date of Policy: ___ ___/___ ___/ ___ ___
Address:	
City, State, Zip:	Telephone:

(Please Complete Back of Form)

Our Financial Policy And How It Works For You

- Whether you are paying cash or using insurance, you are always ultimately responsible for your bill.

Our Responsibilities

- We will bill your insurance for you as a courtesy.
- We will correct any errors we have made when there is a billing dispute.
- We will provide *guidance in getting your bills paid*.

Your Responsibilities

- Please know and understand your insurance coverage.
- Please provide a photocopy of the front and back of your insurance card whenever possible.
- Please pay your deductible, coinsurance or copayment in a timely manner.
- Please read and keep your Explanations of Benefits statements from your insurance company.
- Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.
- **Contact our billing office at (636) 677-3399 with any questions or if you are in need of assistance.**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND AMBULANCE SERVICES

I, ________________________________, hereby authorize North Jefferson County Ambulance District to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and ambulance services. I have been informed that North Jefferson County Ambulance District has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and ambulance services. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying North Jefferson County Ambulance District, in writing, but if I revoke my consent, such revocation will not affect any actions that North Jefferson County Ambulance District took before receiving my revocation. I understand that North Jefferson County Ambulance District has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that North Jefferson County Ambulance District restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or ambulance services. I understand that North Jefferson County Ambulance District does not have to agree to such restrictions, but that once such restrictions are agreed to, North Jefferson County Ambulance District must adhere to such restrictions.

Patient/Guarantor's Signature:____ Date:______________________________