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**AUTHORIZATION AND CONSENT**

**SECTION I**

PATIENT NAME: ALVIN LETNER

UNIT/BASE I.D.: REGAR Date Of Service: 7-13-19 TIME: 1710 (Military Format)

**CONSENT TO TREATMENT.** I accept from Air Methods Corp., its agents and any of its associated companies (together, "Provider") air medical transportation and medical services, administration of medications and blood or blood products, and other medical procedures ("Services") performed by the company listed above and any agent or entity acting on behalf of that company (collectively, "Provider"). I understand that medical care is not an exact science and Provider makes no guarantees about my health outcome.

**RELEASE OF INFORMATION.** I agree to allow Provider to share any part of my medical record or other information needed for billing and payment for services delivered by Provider, now or in the future, to any financially responsible party, including: the Centers for Medicare and Medicaid Services (CMS), their agents, Worker's Compensation carriers, health or liability insurers, and any other insurance organization or billing agent (together, "Insurer"). I agree to allow anyone with medical and billing information about me to release to Provider or Insurer any information necessary for billing and payment purposes. I agree a copy of this form may be used instead of the original.

**ASSIGNMENT OF BENEFITS & RIGHTS.** I agree to allow and request any Insurers to directly, immediately and exclusively pay Provider the proceeds of my benefits up to the full amount of Provider's charges for services delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered by Provider, including the rights to: (1) request and receive any documents or information from any entity or person, including those governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), to the full extent of my rights; (2) appeal any denial or underpayment of benefits or coverage; (3) pursue any legal remedies in any forum and get all available relief (monetary or equitable), including applying all ERISA provisions. These rights assigned to Provider are assigned completely, without any limitations or reservations.

**FINANCIAL RESPONSIBILITY.** I will cooperate with any efforts by Provider to maximize payment of my insurance benefits and minimize my personal financial responsibility. I agree to allow Provider to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insurer for Provider's services, I agree to promptly send such payment to Provider. I understand that many Insurers will only pay for services that meet certain coverage requirements, such as medical necessity. If my Insurer denies or underpays Provider's charges for any reason, or if I have no insurance, I accept direct financial responsibility for any unpaid charges.

**COLLECTIONS & TELEPHONE CONSENT.** I agree to allow Provider to: (1) use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the telephone number provided below, which may be a wireless or cell phone number; (2) leave answering machine or voice mail messages for me, and include in any such messages information required by law (including debt collection laws) or other information about amounts I owe; (3) send text messages or e-mails to the telephone number and e-mail address provided below about unpaid balances or other billing issues. I also agree to allow Provider to get a credit report to help collect unpaid balances.

I have read this information and I am the patient, the patient's legal representative or authorized by the patient as the patient's agent to sign this this Authorization and Consent form and to accept its terms. This Authorization and Consent form contains the complete agreement and any handwritten words or other changes to the typewritten text are invalid and non-enforceable. Changes can only be made by a separate agreement signed by me and Provider.

**SECTION II**

Mark the Appropriate Box and Sign Below:

Signer below is the:  Patient  Authorized Representative (See Back for Definition)  Crew Member (NO Representative was available or willing to sign)

the signer, UNLESS SIGNER IS SPOUSE, PARENT OF

Signature of Crew (patient signs using an "X") ▶▶

Witness Signature (if patient signs with an "X")

**SECTION III**

If Authorized Representative, identify relationship to the Patient (see back for definition):

A (Legal Guardian)  B (Recipient of Government Benefits for patient)  C (Spouse, Parent, or person responsible for patient's affairs)  D (Agency Rep that provided service to patient)

Patient unable to sign (check box, if appropriate and explain below):

SPECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN

**SECTION IV**

**RECEIVING FACILITY ACKNOWLEDGMENT**

FACILITY NAME: FREEMAN WEST

CITY: JOPLIN

ST: MO



PCS

Medical Necessity for Air Medical Transport

Date of Service: 7-13-19

Patient Name: ALVIN LETNER

Flight # 19-109946

Diagnosis: MVC - MOTORCYCLE

Presenting time-critical condition / required intervention: MVC MOTORCYCLE

Ground transport would have been hazardous due to the LENGTH OF TRANSPORT. Ground transport time of 50+ minutes versus air transport time of 20 minutes.

The following information is required for INTERFACILITY TRANSPORTS: Patients Name, Referring physician, Referring hospital, Receiving physician, Receiving hospital, Unit Name, Sending physician has certified under EMTALA...

Based on an assessment of this patient, emergent transportation is required for the following reasons (mark all that apply, minimum of one from both sections):

SECTION 1 - REASON(S) FOR METHOD OF TRANSPORT:

- The patient's condition was TIME CRITICAL, requiring rapid air transportation in order to minimize morbidity / mortality.
The patient's condition met established criteria for transport based on published standards for appropriate utilization of air transport from the EMS, cardiac, trauma, pediatric, or neonatal communities.
During transport, the patient's condition required critical care life support and monitoring by an ALS crew with an attending RN present (specify care): intubated, TPA infusion, IABP, ETCO2 Monitoring, EKG, IV Medications, titrated drips (specify Medications) NS, Heparin
Ground transport would have been hazardous and / or delayed due to: Rush hour / traffic conditions, Unable to leave county, Bridge out/road construction, Adverse weather conditions, Inaccessible by ground, No ground available, Other distance
Ground unable to perform certain interventions: RSI, Blood Product Administration, Medication, Other

SECTION 2 - REASON(S) PATIENT REQUIRED TRANSPORT:

- The receiving facility provides specialized care, treatment, and diagnostics not available at referring facility or a facility that may have been closer to the scene (define care required and facilities needed) TRAUMA SURGERY
No beds or needed specialist available at referring facility (describe unit/bed type/specialist not available at referring facility)
Specialized maternal / neonatal care required with high-risk obstetrician and / or neonatal ICU not available at referring facility. Other maternal / neonatal specialized services needed (describe care required and facilities needed)
Specialized Trauma Care required with diagnostic and trauma surgical facilities readily available. (Describe services not available at referring facility or services needed for scene transport) TRAUMA SURGERY

Mechanism of injury: MVC rollover, MVC with ejection, Head on collision, Same vehicle occupant fatality, Extrication time > 30 minutes, Crash speed change > 20 mph, Pedestrian struck by motor vehicle, Trauma Patient, Pregnant trauma patient, Blast injury, Two or more proximal extremity fractures, Fall 20' > feet, Other (describe):

- Specialized cardiac care facility required with Cath Lab facility and surgical backup readily available, High-risk cardiac surgical candidate, Cath Lab at referring facility not open all hours, Cath Lab at referring facility has no surgical back up (Describe specialized cardiac services needed)

