BELLINGHAM FIRE DEPARTMENT
Whatcom Medic One
1800 Broadway
P.O. Box 366
Bellingham, WA 98227-0366
Tel: (360) 778-8460 FAX: (360) 778-8469

Mayor Kelli Linville
Fire Chief Bill Newbold
Office Manager: Kristi Clift
www.cob.org/fire

Today's date: _____

Please return this completed form as soon as possible by fax or mail as indicated above.
A copy of this form is as valid as an original.

Patient Name: _____ Date of Service:_____

All signers: By signing below, the signer acknowledges that Bellingham Fire Department/Whatcom Medic One (BFD/WMO) provided a copy of, or access to, its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

Patient Signs: By signing below, I;

- Authorize BFD/WMO to submit a claim to Medicare, Medicaid, or any other payer for any services provided to me by BFD/WMO now, in the past or in the future, until such time as I revoke this authorization in writing.
- Understand that I am financially responsible for the services and supplies provided to me by BFD/WMO, 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.
- Agree to immediately remit to BFD/WMO 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 BFD/WMO.
- Authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to BFD/WMO and its billing agents, the Centers for Medicare and Medicaid Service, 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 BFD/WMO, now, in the past, or in the future.
- Authorize BFD/WMO to obtain medical, insurance, billing and other relevant information about me from any party, database, or other source that maintains such information.

Patient Representative signs: By signing below, I acknowledge that I am;

- Signing because the patient is physically/mentally unable to sign (list reason below)
- Not accepting financial responsibility for the services rendered.
- 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 BFD/WMO now or in the past, (or in the future, where permitted).
- One of the following:
    - Patient's legal guardian
    - Relative or other person who arranges for the patients treatment or exercises other responsibility for the patients affairs
    - Representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the patient.

Patient signature:_____ Witness:_____
(if patient signs with mark or 'x')

Representative signature: _____ Print Name:_____

Representative Address: _____

Physical/mental reason patient is unable to sign: _____