PATIENT CONSENT & ASSIGNMENT OF BENEFITS (AOB)

PATIENT NAME______________________________**TRANSPORT #**____________________
DATE OF SERVICE______________**UNIT/BASE ID**______________**TIME (MILITARY FORMAT)**__________

As a condition of receiving emergency transport & treatment by OSF AVIATION, LLC, I hereby agree to the following:

1. Consent to Treatment: The Undersigned consents to transport & treatment by **OSF AVIATION, LLC**, deemed necessary in the judgment of the OSF Aviation, LLC's medical crew. I am aware that the practice of medicine is not an exact science. No representations or guarantees have been made regarding the result of the Services.
2. Insurance Certification & Authorization: I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other private or public insurance carrier(s) or third party insurance carrier (collectively, "Insurance Carriers") have been obtained. I recognize that my Insurance Carrier may reduce benefits if these are not obtained and that I am responsible for any balance not paid by it. I recognize that some or all of the Services may be deemed not medically necessary by my Insurance Carrier, & that in such event, I may be responsible for the entire unpaid balance of OSF Aviation, LLC's charges. I agree to sign any documents necessary to authorize **OSF AVIATION, LLC** to contest any insurance denial.
3. Guarantee of Payment & Assignment of Benefits: I agree to pay OSF Aviation, LLC's charges for the Services, including but not limited to any co-payments, deductibles or other expenses not covered by insurance. Unless otherwise specifically agreed in writing or provided by law, all charges shall be due & payable on receipt of invoice. Unpaid accounts **MAY** bear interest at the rate of 12% per annum, not to exceed the maximum amount permitted by law. Without limiting the foregoing, to the full extent necessary to pay OSF Aviation, LLC's charges in full, & subject to any limitations imposed by applicable law, I assign & transfer to **OSF AVIATION, LLC** all my rights in & to: **(a)** all insurance benefits (whether such insurance is owned by me or not) payable as a result of the injury or medical condition that necessitated the Services: **(b)** any & all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the injury or medical condition necessitating the Services; **(c)** any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the injury or medical condition which necessitated the Services. To the full extent permitted by law, I specifically instruct any attorney, insurance agent, or other party who represents me to abide by this assignment & to disburse from the attorney's trust account or other depository to **OSF AVIATION, LLC** any insurance proceeds necessary to pay OSF Aviation, LLC's charges in full. I also assign & request payment of authorized Medicare, Medicaid or other government & private health benefits be made directly to **OSF AVIATION, LLC**. Acceptance of this assignment by **OSF AVIATION, LLC** shall not constitute an undertaking by **OSF AVIATION, LLC** or any duty to secure payment of any of the benefits hereby assigned. This assignment shall not be deemed to be in substitution for any right or remedy which **OSF AVIATION, LLC** may have to secure & obtain full payment of its charges directly from the undersigned. All rights & remedies of **OSF AVIATION, LLC** pursuant to this agreement & by law are cumulative & the exercise of any right or remedy shall not be to the exclusion of the exercise of any other right or remedy.
4. Release of\Liability for Personal Valuables: I understand & agree that **OSF AVIATION, LLC** is not responsible for personal valuables or belongings brought into the ambulance by me or my representative, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry & money.
5. Consent for Release & Use of Information: I authorize any holder of medical or other information about me to release to Medicare, Medicaid or any other Insurance Carrier or their agents any information needed to determine benefits for this or a related claim, or for any other purpose permitted by law.
6. **Acknowledgement of Receipt of Notice of Privacy Practices:** I acknowledge receipt of OSF Aviation, LLC's Notice of Privacy Practices.
7. **Release of Police Reports**: I appoint **OSF AVIATION, LLC** as my representative, under applicable State law; for the purpose of obtaining police reports & other data related to the accident or incident for which Services were provided.
8. **Severability; Entire Agreement; Attorney's Fees:** In the event any provision of this Agreement is held to be invalid or unenforceable by a court of competent jurisdiction, such finding shall have no effect upon the validity or enforceability of the remaining portions hereof. The invalid or unenforceable provision shall be deemed severed & the remaining provisions hereof shall remain in full force & effect. This Agreement constitutes the entire agreement between **OSF AVIATION, LLC** & the undersigned. If any action at law or in equity is brought to enforce this Agreement, **OSF AVIATION, LLC** shall be entitled to recover reasonable attorney's fees, court costs, & any other costs of collection incurred. The undersigned has read this Agreement, has had an opportunity to ask any questions, has received satisfactory answers thereto & enters into it voluntarily.

Patient Signature or Other Mark "X"______________________________**Date**__________
If Patient signs with an "X" or other Mark, a witness must also sign:______________**Date**__________

If this section has been completed then the signature requirement has been met; if Patient is unwilling or unable to sign proceed to next section

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If patient is unwilling or physically or mentally incapable of signing then an authorized representative must sign:

PATIENT UNABLE TO SIGN (MUST document physical or neurological limitation)____________________

Authorized Representative Statement: My *signature below indicates that, at the time of service, the Pt named above was physically or mentally incapable of signing. My signature is not an acceptance of financial responsibility for the services rendered to this pt.*

Authorized Representative Signature____
Printed Name/Credentials______________________________**Date**__________
Indicate the relationship of the authorized representative to the Patient:

- ☐ the patient's legal guardian;
- ☐ a relative or other person who receives governmental benefits on the patient's behalf;
- ☐ a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs;
- ☐ a representative of an agency or institution which furnished other care or services to the beneficiary; such as referring facility

If this section has been completed then the signature requirement has been met; if Auth. Rep. is unavailable/unwilling to sign, proceed to next section

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If patient is physically or mentally incapable of signing & no authorized representative is available or willing to sign:

PATIENT UNABLE TO SIGN (MUST document physical or neurological limitation)____________________

Crew Member and/or Receiving Facility Representative Statement: My signature below indicates that, at the time of services, the Pt named above was physically or mentally incapable of signing & that none of the Authorized Representatives listed above were available or willing to sign on the Pt's behalf. My signature is not an acceptance of financial responsibility for the services rendered to this Pt.

Crew Member Printed Name/Credentials________________ **Signature**____________**Date**______
&
Receiving Facility Rep Printed Name/Credentials ____________ **Signature** ____________**Date**______
Name & Location of Receiving Facility______________________________**Time at Rec. Fac.**______

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