Denton Fire Department
Patient Release of Responsibility

Patient Name: ___________________________________ **Current Date:** _________________

________**Patient Release** I have been informed of the reason the emergency medical personnel feel that I should go to the emergency center for further evaluation.
I have been informed of the evaluation and/or treatment that may/will occur at the emergency center.
I have been informed of the consequences and/or complications that may result due to my refusal to go to the emergency center for further evaluation.

________I understand that I am financially responsible for the services provided to me by the City of Denton Fire Department regardless of insurance coverage.

By signing below I acknowledge that I have received notice of the Denton Fire Department Notice of Privacy Practices.
Copies of this notice are available at no charge upon request. A copy of this form is valid as the original.

Initial one of the following

REFUSE TREATMENT AND TRANSPORT

______ I, the undersigned, have been advised that emergency medical treatment on my/the patient's behalf is necessary, and that refusal of recommended treatment **and/or** transport to an emergency center may result in death, or imperil my/the patient's health by increasing the opportunity for morbidity. Nevertheless, and understanding all of the above, I REFUSE TO ACCEPT FURTHER EMERGENCY MEDICAL TREATMENT AND/OR TRANSPORTATION TO AN EMERGENCY CENTER, assume all risks and consequences resulting from my decision and release the EMS Department(s) and its member(s) from any and all liability which may occur from my decision not to accept their recommendation.

REFUSE TREATMENT

______I ACCEPT TRANSPORT ONLY AND REFUSE ALL TREATMENT AND/OR SPECIFIC TREATMENTS
WHICH THEY MAY RENDER. I have been advised of the possible consequences that may result from the decision not to accept further treatment, and release the EMS Department(s) and its member(s) from any and all liability that may occur. (Note treatment refused in narrative.)

As a competent adult, I fully understand all the above and am capable of determining a rational decision on my behalf.

Patient/Surrogate Signature X_______________________________________	**Date** / /	**Witness Signature** X____________________________________	**Date** / /
Printed name and relationship, if other than Patient		**Printed Name of Witness**	
Patient Name	**SSN**	**Date of Birth**	**Phone**
Patient Address ***(Address, City, ST, ZIP)***			**Patient's Initials:** _______

Relationship of Guardian/Witness to Patient: ____

Reason Patient was Unable to Sign (if applicable): ____

EMS Assessment

☐ Patient was AAOx4 ☐ BP_______/______

☐ Patient denied ETOH or drug use ☐ Pulse___________

☐ Patient denied suicidal/homicidal ideation ☐ Resp.___________

Provider Signature__________________________ **Printed Name**____________________________ **Date** _______________

Rev. 09/2015

Denton Fire Department
Patient Signature Form- Assignment of Benefits

Patient Name:______________________ DFD Incident:_______________ Transport Date:______________

I understand that I am financially responsible for the services and supplies provided to me by **Denton Fire Department**, 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 authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by **Denton Fire Department** now, in the past, or in the future. I agree to immediately remit to **Denton Fire Department** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and assigns all rights to such payments to **Denton Fire Department**. I authorize **Denton Fire Department** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to **Denton Fire Department** and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payors or insurers, and their respective agents to contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Denton Fire Department, now in the past or in the future.

Patient hereby consents to being contacted by **Denton Fire Department**, or by any agents or other entities acting on behalf of **Denton Fire Department**, by telephone, cell phone, email or other methods of communication in connection with the billing or collection of amounts due, or otherwise in connection with the services rendered by the **Denton Fire Department**, and/or payment therefore, including, without limitation, calls (including text messages) to any telephone number assigned to a cellular telephone service, and including any such calls made using an automatic telephone dialing system and/or an artificial or prerecorded voice.

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **Denton Fire Department** provided access to a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the notice to the patient.

_________________________________ _________________________________ __________________
Patient Signature Printed Name Date

If the patient signs with an "X" or other mark, a witness should sign below

_________________________________ _________________________________ __________________
Witness/Crew Signature Printed Name/Crew # Date

Receiving Facility: ___________________________ Date:_____________ Time:_____________

Facility Representative Name:_______________________ Facility Representative Signature:________________

NOTES: ____

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