



“Your Non-Profit Community Ambulance Service”

On \_\_\_\_/\_\_\_\_/\_\_\_\_, Patient \_\_\_\_\_  
(Date) (Patient's Name)

was given notice of the Privacy Practices of Allied E.M.S. Systems, Inc. by:

\_\_\_\_\_, Incident #: \_\_\_\_\_  
(Allied Employee)

***Explanation of the good faith efforts that was made to provide such notice to the patient after the emergency treatment situation was over.***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Name of Employee) (Date)

**GUARANTOR OF PAYMENT \*\*\*\*\* HIPAA PRIVACY NOTICE**

In consideration of the services rendered, the undersigned does hereby agree to pay and guarantee payment in full any and all charges for services rendered and materials furnished to or for patients by Allied E.M.S. Systems, Inc.

Release of medical records: I hereby authorize release of ambulance records to any insurance company (or to any governmental agency or unit) in any way involved in payment of all or part of this ambulance bill. I understand that if any part of the ambulance bill is not part of the benefits provided by my insurance company, that I will be responsible for all or part of the non-covered service which was provided for me. I also acknowledge that I was provided with a copy of Allied E.M.S. Systems, Inc. Notice of Privacy Practices.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Guardian Unable to Sign: \_\_\_\_\_, \_\_\_\_\_  
(Allied Employee Signature) (Please Print)