HIPAA Notice of Privacy Practices

Ogdensburg Volunteer Rescue Squad, Inc
101 State Street, PO Box 172
Ogdensburg, New York 13669

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Ogdensburg Volunteer Rescue Squad, Inc. is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. Ogdensburg Volunteer Rescue Squad, Inc. is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: Ogdensburg Volunteer Rescue Squad, Inc. may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Reminders for Scheduled Transports and Information on Other Services. We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provide information about other services we render.

Use and Disclosure of PHI Without Your Authorization. Ogdensburg Volunteer Rescue Squad, Inc. is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;

Staple copy of PCR/Runform
& Hospital Face Sheet Here

Ogdensburg Vol. Rescue Squad

Patient's Name:		Social Security Number:	D.O.B.	Sex: Male Female
Address (Street):	PO Box:	City:	State:	Zip:
Phone #:				

INSURANCE INFORMATION

Medicare Number:	Medicaid Number:

Primary Insurance: Blue Cross Tri-Care Rail Road Health Auto Workers Comp.		Secondary Insurance: Blue Cross Tri-Care Rail Road Health Auto Workers Comp.	
Policy Number:	Group Number:	Policy Number:	Group Number:
Insured Name:	Relationship: Self Spouse Parent Other	Insured Name:	Relationship: Self Spouse Parent Other
Insurance Company Name:		Insurance Company Names:	
Address, City, State Zip		Address, City, State Zip	

I hereby assign to Ogdensburg Volunteer Rescue Squad, hereinafter the Provider, all rights, privileges and remedies to payment for health care services provided by the Provider to which I am entitled under my health insurance policy, entitlement plan, Medicare, Medicaid or under Article 51 (the No-Fault statute) of the Insurance Law. I authorize the holder of hospital or medical information about me to be released to CMS or its agents and carriers as well as to the Provider of any information or documentation needed to determine these benefits or the benefits payable for related services.

The Provider hereby certifies that they have not received any payment from or on behalf of the patient and shall not pursue payment directly from the patient for services provided by the Provider for injuries sustained due to illness, injury or motor vehicle accident which occurred on this date, not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the patient's lack of coverage and/or violation of a policy condition due to the actions or conduct of the patient. I permit a copy of this authorization to be used in place of the original. I acknowledge that I was provided with or have the ability to request a copy of the Ogdensburg Volunteer Rescue Squad's Notice of Privacy Practices. I understand that the supplier for all services may use this authorization in the future until such time as I revoke this authorization in writing.

Section I - Patient Signature for Emergency & Non-Emergency Transport

Patient's/Responsible Party's Signature: X ______________________ Date: ______________

If Patient signs with an "X" or other mark, it is recommended that a witness sign below.

Witness Signature: X ______________________ Printed Name: ______________________

Section II - Authorized Representative Signature for Emergency & Non-Emergency Transport

Complete this Section only if the patient is Physically or Mentally incapable of signing.

Reason Patient is Unable to Sign:

Authorized Representatives include only the following individuals (check one)

[ ] Patient's Legal Guardian
[ ] Patient's Power of Attorney
[ ] Relative or other person who receives government benefits on behalf of Patient.
[ ] Relative or other person who arranges treatment or handles the patient's affairs
[ ] Representative of an agency or institution that furnished care, services or assistances to the patient

I am signing on behalf of the patient. I recognize that signing of behalf of the patient is not an acceptance of financial responsibility for the services rendered.

Representatives Signature: X ______________________ Printed Name: ______________________

Section III - EMERGENCY ONLY - Ambulance Crew and Facility Representative Signatures

Complete this section only if all of the following are true: (1) the call is an emergency ambulance transport, (2) the patient was physically or mentally incapable of signing, and (3) no authorized representative from Section II was available or willing to sign on behalf of the patient at time of service.

Reason Patient is Unable to Sign:

Signature of Crew Member: X ______________________ Time Received:

Printed Name: ______________________

The patient named on this form was received by this facility at the date and time indicated above. This signature is not an acceptance of financial responsibility for the services rendered to this patient.

Patient Accepted by Hospital Representative: X ______________________ Title: ______________________

If Receiving Facility Signature can not be obtained, secondary documentation in the form of a Facility Face Sheet or Admissions Record clearly indicating the time and date is required from the facility. The release of this information by the hospital to the ambulance service is expressly permitted by Section 164.506(c) of HIPAA.

Date of Service:	Run Number:	Destination:	Level of Care:	Loaded Mileage:	Time of Call:
Pickup Location: Same as Above: YES NO		City:		State:	Zip Code:
Auto Accident: YES NO	Work Related: YES NO	ALS Intercept: YES NO	ALS / BLS Provider: Unit #		Subscriber: YES NO

Revised 4/1/2008
2008 EMS RR Form