

Skilled Patient / Bill Facility Agreement

This agreement is for **non-emergency transports** to Doctor offices and follow up appointments of skilled patients and hospital discharges. This agreement **is not required** for any patient whose destination is the **Emergency Room**. This agreement will be completed and faxed to *Amelia Ambulance Service* at **804-561-1658** at the time an appointment is scheduled. The appointment will not be scheduled unless this agreement is received. If the patient is to be financially responsible for the transport it must be noted below and authorized by our billing office before an appointment will be scheduled.

Today's Date

Patient Name

Birth Date

Social Security

Your Facility Name

Patient's Room No.

Destination

Purpose of Visit

Doctor To Be Seen

Appointment Date

Appointment Time

Doctor Phone Number

I _____ authorize *Amelia Ambulance Service* to transport the patient mentioned above at the date and time requested. I authorize *Amelia Ambulance Service* to bill our facility and acknowledge financial responsibility for the transport of this patient.

The patient is financially responsible for this transport.

Signed:

Date

Administrator Director of Nursing

Social Services Charge Nurse