

# BILLING AUTHORIZATION / RESPONSIBILITY FOR PAYMENT

Snohomish County Fire District 3,5,7,17,19,26,28, or the City of Bothell

I understand that I am financially responsible for the services provided to me by Snohomish County Fire District 3,5,7,17,19,26,28, or the City of Bothell regardless of insurance coverage. I authorize that payment of insurance benefits, including Medicare and Medicaid, be made on my behalf to the provider or its billing agent for any and all services provided to me. I authorize and direct any holder of medical information or documentation about me to be released for determination of benefits or benefits payable for any service provided to me, now or in the future. I agree to immediately remit any payment that I receive from any source directly to the provider for the services provided to me. I understand that if the insurance company does not respond to or denies this claim, I am responsible for payment. A copy of this form is as valid as the original.

*Signature of Patient (or other Authorized Person):*

\_\_\_\_\_ *Date* \_\_\_\_\_

*Patient's Printed Name*

\_\_\_\_\_

*Relationship to Patient:*

\_\_\_\_\_

## CAREGIVER AUTHORIZATION

It is my impression that the patient is physically or mentally incapable of signing. I am **NOT** assuming any personal financial responsibility for this claim, but I do authorize medical records release as stated above.

\_\_\_\_\_ *Date* \_\_\_\_\_  
*Signature of Caregiver*

**Your run number is:**