Phone - 509-248-2004 Toll Free 877-512-6996 Fax - 1-206-691-8689

Authorization for Personal Mobility Aid Transportation Services

Transportation Date:_____/_____/_____**P/up Time**_____**Appt Time**_____
Client Name:_____ DOB _____
Pickup Address:_____City:_____
Drop off Address:_____City:_____

Special Considerations:

Does the client need a Bariatric Board? Y_____N_____
*** *Please note*, due to weight restrictions please indicate weight_____.**
**** *Please note*, If the client is going for an appointment a family member or care attendant must accompany the client.**

HEALTHCARE PROFESSIONAL/PHYSICIAN'S CERTIFICATION STATEMENT

The undersigned certifies the following; his/her Physician has evaluated and is familiar with the individual's condition, considers it safe for the individual to transfer to a personal mobility aid, medical care or monitoring is not required during transport, the individual is not experiencing an acute condition or worsening of a chronic condition the individual is capable of self or personal attendants care, and has determined that the individual's condition merits a lying down position and transportation is appropriate by Medstar Transportation.

_____
Health Professional Signature Date

_____
Health Professional (Print Name)

INDIVIDUAL'S CERTIFICATION STATEMENT

The undersigned certifies the following; this service is requested for the purpose of conducting daily living activities or to attend a pre-scheduled medical appointment, ambulance services are not preferred, the individual or their representative, own(s)/leases(s)) the personal mobility aid used during transport. The undersigned accept financial responsibility for transportation and associated services.

_____
Individual or representative Signature Date

_____
Individual or Representative (Print Name)

*******For official MEDSTAR TRANSPORTATION use only*******

Payment Type_____ Payment is in QB's Yes_____No_____
A Bariatric Board is required? Yes_____No_____Clients Weight_____Portable O2 Yes_____
From private home, 2 people will be there to assist client to the COT Yes_____ Is there a Hoyer lift?_____
If Yes, confirm someone will be there to operate the lift.
Operator #1_____Operator #2 _____
For appointments, a PCA or an attendant has been secured? Yes_____No_____Number of Stairs _____
Trip was confirmed the day before? Yes_____No_____Info sent to Lead Operator? Yes_____No _____

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CREDIT CARD AUTHORIZATION FORM

Is this a House Account with Medstar Transportation?_____Y_____N

If not a House Account, please fill out the information.

Contact Info:_____Phone: _____

I,_____authorize Medstar Transportation to charge on my credit card the following:

We will not keep the Credit Card on File.

Credit Card Number:_____/_____/_____/ _____
M/C VISA AMEX Discover

Credit Card Cardholders Name: _____
(exactly how it appears on the card)

Expiration Date:_____/ _____
Month Year

Signature Panel Code: - V CODE _____

Credit Card Bill Address: _____

Email Address for Receipt: _____

X _____
Signature of Cardholder

Return this form to dispatch@gomedstar.com or fax to 1-206-691-8689

Thank you for the business.