

# ISLAND AIR AMBULANCE

## MEMBERSHIP APPLICATION

Rev.03.19.16

\_\_\_\_\_  
\*Printed Name of Person Applying for Membership

\_\_\_\_\_  
\*Home Phone Number

\_\_\_\_\_  
\*Insurance Provider

\_\_\_\_\_  
\*Date of Birth

\_\_\_\_\_  
\* eMail Address

\_\_\_\_\_  
\*Mailing Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Membership Level:

\_\_\_\_\_  
1 Year – \$39 [Regular \$55]

\_\_\_\_\_  
3 Year - \$119 [Regular \$165]

\_\_\_\_\_  
Vacation (3 continuous months) - \$25

**Family Information:** Island Air Ambulance Membership covers the main subscriber, spouse or domestic partner and all family members eligible to be claimed on the main subscriber's income tax.

Printed Names, Relationship, and Dates of Birth of All Adult and Minor Subscribers in Household

\*Name, Relationship:

\*Date of Birth:

\*Insurance Provider:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\* Required fields, incomplete memberships may cause a delay in enrollment.

### Signature Acknowledgement:

I apply for participation as a member in the Membership Program of Island Air. I agree to the Island Air Membership Program Terms and Conditions described in the accompanying materials and on our website. I verify that I am not a Medicaid beneficiary and that I do have health insurance. I request payment of authorized Medicare or any other insurance benefits be made on my behalf to Island Air for any ambulance services provided to me by Island Air now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Island Air regardless of my insurance coverage, and in some cases, I may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Island Air any payments that I receive directly from my insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Island Air. I authorize Island Air to appeal payment denials or other adverse actions on my behalf without further authorization and direct any holder of medical information or other relevant documentation about me to release such information to Island Air, its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors as may be necessary to determine these or other benefits payable for any services provided to me by Island Air now, in the past, or in the future. A copy of this form is valid as an original.

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this Membership Program, and I hereby apply to be a member of Island Air. By signing below, I also acknowledge that I have received a copy of Island Air's Notice of Privacy Practices, which is also available online at <https://islandairambulance.com/Privacy-Practices>.

\_\_\_\_\_  
\*Signature of Primary Member, also authorized to  
sign for minor household members.

\_\_\_\_\_  
Date

**ISLAND AIR AMBULANCE**  
**MEMBERSHIP APPLICATION**

Rev.03.19.16

**Payment Information**

Check enclosed [Please make out to Island Air, Inc.]

Please charge my:

Mastercard  Visa

\_\_\_\_\_  
*Names as it appears on card*

\_\_\_\_\_  
*Account number*

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

\_\_\_\_\_  
*CVC code*

\_\_\_\_\_  
*Signature*



*Please send completed application along with payment information to:*

**Island Air Ambulance Membership Program**

72 Airport Circle Dr  
Friday Harbor, WA 98250

*Application and electronic payment information can also be sent to:*  
[membership@islandairambulance.com](mailto:membership@islandairambulance.com) or faxed to (360) 378-3199.

Complete Terms and Conditions can be found online at: <https://islandairambulance.com/Terms-&-Conditions>

# Island Air Inc. Notice of Privacy Practices

Rev.03.19.16

**IMPORTANT: 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.**

As an essential part of our commitment to you, Island Air Inc. maintains the privacy of certain confidential health care information about you, known as Protected Health Information or PHI. We are required by law to protect your health care information and to provide you with the attached Notice of Privacy Practices.

The Notice outlines our legal duties and privacy practices with respect to your PHI. It not only describes our privacy practices and your legal rights, but lets you know, among other things, how Island Air Inc. is permitted to use and disclose PHI about you, how you can access and copy that information, how you may request amendment of that information, and how you may request restrictions on our use and disclosure of your PHI.

Island Air Inc. is also required to abide by the terms of the version of this Notice currently in effect. In most situations we may use this information as described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE ATTACHED DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT OUR PRIVACY OFFICER, AT (360) 378-2376

**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.**

**OUR OBLIGATIONS:** We are required by law to: Maintain the privacy of protected health information; Give you this notice of our legal duties and privacy practices regarding health information about you; and follow the terms of our notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:** The following categories describe ways that we may use and disclose health information that identifies you ("Health Information"). Every type of use or disclosure of Health Information in a category is not listed. Except for the purposes described below, we will use and disclose Health Information only with your written permission. If you give us permission to use or disclose Health Information for a purpose not discussed in this notice, you may revoke that permission, in writing, at any time by contacting Privacy Officer at (360) 378-2376.

***For Treatment.*** We may use Health Information to treat you or provide you with health care services. We may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our facility who may be involved in your medical care. ***For Payment.*** We may use and disclose Health Information so that we or others may bill or receive payment from you, an insurance company or a third party for the treatment and services you received. ***For Health Care Operations.*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. ***Fundraising Activities.*** We may use Health Information to contact you in an effort to raise money. We may disclose Health Information to a related foundation or to our business associate so that they may contact you to raise money for us. ***Individuals Involved in Your Care or Payment for Your Care.*** We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. ***Research.*** Under certain circumstances, we may use and disclose Health Information for research purposes. Before we use or disclose Health Information for research, though, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, so long as they do not remove or take a copy of any Health Information.

**SPECIAL CIRCUMSTANCES:** ***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law. ***To Avert a Serious Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat. ***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. ***Organ and Tissue Donation.*** 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 or tissue donation and transplantation. ***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. ***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. ***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; notify a person who may have been exposed to a disease or may

be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of the hospital in certain limited circumstances concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; however, we will only release this information if you agree or when we are required or authorized by law. **Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. **Law Enforcement.** We may release Health Information if asked by a law enforcement official for the following reasons: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime. **Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**YOUR RIGHTS:** You have the following rights regarding Health Information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. To inspect and copy this Health Information, you must make your request, in writing, to Island Air Inc. Privacy Officer, 72 Airport Circle Drive, Friday Harbor, WA 98250.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request, in writing, to Island Air Inc. Privacy Officer, 72 Airport Circle Drive, Friday Harbor, WA 98250.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of Health Information we made. To request an accounting of disclosures, you must make your request, in writing, to Island Air Inc. Privacy Officer, 72 Airport Circle Drive, Friday Harbor, WA 98250.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. In addition, you have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about your surgery with your spouse. To request a restriction, you must make your request, in writing, to Island Air Inc., Privacy Officer, 72 Airport Circle, Friday Harbor, WA 98250.

**We are not required to agree to your request.** If we agree, we will comply with your request unless we need to use the information in certain emergency treatment situations.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to Island Air Inc. Privacy Officer, 72 Airport Circle Drive, Friday Harbor, WA 98250. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, call (360) 378-2376

#### **CHANGES TO THIS NOTICE:**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current notice at our place of business. The notice will contain the effective date on the first page, in the top right hand corner.

#### **COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with us, or the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Privacy Officer at (360) 378-2376. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Island Air Inc.  
72 Airport Circle Drive Friday Harbor, WA 98250  
(360) 378-2376