DiagnosTEX Authorization/Consent Form (please read thoroughly
Patient Name: Referring Healthcare provider: Contact information:
Patient or Responsible Party must <i>initial</i> all bulleted items and sign at the bottom of the page All signatures must be obtained prior to the MBSS, please include all other required paperwork, this form alone does not initiate care.
, authorize to DiagnosTEX LLC and PLLC:  To proceed with a Dysphagia Consultation including Modified Barium Swallow (MBS) study to determine the presence of dysphagia in the oral and pharyngeal stages as well as thoracic esophagus and cervical spir assessment. I acknowledge there is no guarantee as to the outcome of the results and recommendations. An untitle copy of the exam may be used for educational purposes in healthcare field.
<ul> <li>Authorization to use and disclose my medical information to bill and collect payment for services furnished me by DiagnosTEX, LLC and/or PLLC. I hereby assign and transfer to DiagnosTEX, PLLC all rights, titles and intere benefits payable on all my insurance carriers. I authorize DiagnosTEX to initiate a complaint to the insurance Commissioner for any reason on my behalf.</li> </ul>
<ul> <li>Authorize assignment of all medical benefits to which I am entitled, Medicare Part B, Medicaid or Other Private Insurance to DiagnosTEX, PLLC. This assignment will remain in effect until revoked by me in writing. photocopy of this assignment is to be considered as valid as the original.</li> </ul>
As the Responsible Party I,, agree to the following statements:  •It is my responsibility to pay any deductibles, co-pays or any other balance not paid by my insurance company.
<ul> <li>In the event insurance eligibility cannot be determined or denies payment; I am responsible for payment of all charge DiagnosTEX, PLLC accepts cash, personal checks, money orders, credit cards and patient financing options.</li> </ul>
In the event my insurance company reimburses me in error, this payment will be forwarded to DiagnosTEX, PLLC.
<ul> <li>I have been informed of DiagnosTEX, LLC and PLLC HIPAA privacy notice and have also been informed that a cop is available to me on request. I consent to release my PHI, medical records and status pertaining to the Dysphagia Consultatio including radiological exams to the referring physician and referring clinician</li> </ul>
<ul> <li>My referring/treating healthcare professional may temporarily access my patient portal on my behalf to obtate documentation on the diagnostic exam completed by DiagnosTEX.</li> <li>Email address of policy holder or POAN</li> </ul>
Patient's name (Print)
Signature of Policy Holder of Claimant
Witness signature required if individual is unable to sign independently  Witnesses must be employed by the facility. Preferably DON or administrative staff, if unavailable, nursing staff may sign Witness:
If received verbal consent only, please document in medical chart and sign below  Consent received from Date received:  Relationship to patient:PatientGuardian/POAHealth Care Proxy  Staff Signature Staff Title