DiagnosTEX Authorization/Consent Form

Please read thoroughly

Patient or Responsible Party must *initial* all bulleted items and sign at the bottom of the page

I 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 spine assessment. I acknowledge there is no guarantee as to the outcome of the results and recommendations. An untitled copy of the exam may be used for educational purposes in healthcare field.

- _____Authorization to use and disclose my medical information to bill and collect payment for services furnished to me by DiagnosTEX, LLC and/or PLLC. I hereby assign and transfer to DiagnosTEX, PLLC all rights, titles and interest benefits payable on all my insurance carriers. I authorize DiagnosTEX to initiate a complaint to the insurance Commissioner for any reason on my behalf.

- _____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. A photocopy of this assignment is to be considered as valid as the original.

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.

- _____In the event insurance eligibility cannot be determined or denies payment; I am responsible for payment of all charges. DiagnosTEX, PLLC accepts cash, personal checks, money orders, credit cards and patient financing options.

- _____In the event my insurance company reimburses me in error, this payment will be forwarded to DiagnosTEX, PLLC.

- _____I have been informed of DiagnosTEX, LLC and PLLC HIPAA privacy notice and have also been informed that a copy is available to me on request. I consent to release my PHI, medical records and status pertaining to the Dysphagia Consultation, including radiological exams to the referring physician and referring clinician

- _____My referring/treating healthcare professional may temporarily access my patient portal on my behalf to obtain documentation on the diagnostic exam completed by DiagnosTEX.
  Email address of policy holder or POA _____☐NA

Patient's name (Print)_____

Signature of Policy Holder of Claimant_____ **Date:**_____

All signatures must be obtained prior to the MBSS

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:_____ Title:_____

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If received verbal consent only, please document in medical chart and sign below

Consent received from_____Date received: _____

Relationship to patient: ☐Patient ☐Guardian/POA ☐Health Care Proxy ☐_____

Staff Signature_____ Staff Title_____