DiagnosTEX Home Health Required Paperwork

Consultants in Dysphagia Evaluation and Management

Phone: 817-514-6271 Fax: 817-514-6278

Patient Authorization and Acknowledgement Form

ATTN: Patient/Family or Caregiver

Please thoroughly read the statements below and acknowledge by initialing each line, signing and dating at the bottom of the page. Thank you.

1. **DiagnosTEX is a mobile clinic that will arrive at the home address to complete a Modified Barium Swallow Study inside the mobile clinic. A travel fee of $25.00 is due upon arrival or before arrival. _____(initials required)**

2. **All scheduled home health's must answer the phone to receive the estimated time of arrival and confirm the patient to be seen is there on the day of the study, prior to arrival. *******If there is no answer at the home, on our way to the location, the study will be cancelled for that day***************. _____ (initials required)**

3. **Patient, Family, and/or caregiver are aware that they will be required to exit their home to enter the mobile clinic. If the patient is not ambulatory, they must have their own wheelchair, and a ramp to exit the home. If this is not available, DiagnosTEX will not be able to perform the MBSS. _____(initials required)**

4. **The patient, family, and/or caregiver are aware that DiagnosTEX staff may be required to enter the home to evaluate the patient's medical status and/or form of transportation to the mobile clinic on site. DiagnosTEX staff will not enter the home unless someone is available to answer the door. _____ (initials required)**

5. **The patient should be up, dressed for appropriate weather conditions, and ready to be transported outside to the mobile clinic. DiagnosTEX staff is NOT responsible for transferring patients out of the bed into a wheelchair or transport from an upstairs location. _____ (initials required)**

6. **If DiagnosTEX arrives at the location of the patient and the patient refuses to participate or unable to be transported to the mobile clinic for any reason, a flat fee of $150.00 will be charged for the medical staff's time and travel expenses to the location. _____ (initials required)**

Signature:_____ Date_____

Please return a signed copy of one and keep a copy for you own personal records.