DiagnosTEX Authorization/Consent Form

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

This signed documents grants the following 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. An untitled copy of the exam may be used for educational purposes in the 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.

- _____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:

- _____I understand 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 understand that I am responsible for payment of all charges.

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

DiagnosTEX, PLLC accepts cash, personal checks, money orders, credit cards and patient financing options.

I authorize the DiagnosTEX, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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.

Patients name (print):_____ **Date:**_____
Signature of Policy Holder of Claimant_____
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
Witness:_____ Title:_____
Preferably DON or administrative staff, if unavailable, nursing staff may sign
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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_____