MBS MOBILE IMAGING

Authorization/Consent Form (please read thoroughly)

Patient Name: _____ **Referring Healthcare Provider**: _____
Contact Information: _____

Patient or Responsible Party must *initial* all billeted 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

I, _____, **authorize to MBS-Mobile Imaging:**

- _____To proceed with a Dysphagia Consultation including Modified Barium Swallow (MBS) study to determine the presence of dysphagia in the oral and pharyngeal stages. 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 the healthcare field.
- _____Authorization to use and disclose my medical information to bill and collect payment for services furnished to me by MBS-Mobile Imaging. I hereby assign and transfer to MBS-Mobile Imaging all rights, titles and interest benefits payable on all my insurance carriers. I authorize MBS-Mobile Imaging 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 MBS-Mobile Imaging. 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. MBS-Mobile Imaging 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 MBS-Mobile Imaging
- _____I have been informed of MBS-Mobile Imaging 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

Patient's name (Print) _____

Signature of Policy Holder of Claimant _____ Date: _____

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: _____

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_____