MBS ADVANTAGE, INC. 314-842-1900

PATIENT CONSENT FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION AND AUTHORIZATION TO EVALUATE

In signing this form, you consent to the use and disclosure of your protected health information by MBS Advantage Inc., our staff, and business associates strictly for the purpose of treatment, payment, and health care operations. You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review this Notice if you wish as it may change. A current copy may be requested when you are being seen by contacting our office manager at 314-842-1900. You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement. You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. See Notice of Privacy Practices for further information.

I hereby authorize MBS Advantage, Inc. to evaluate me under the plan of treatment as authorized by my physician(s). This evaluation may include one or all of the following procedures as indicated: Physician Consultation, Videofluoroscopic view of the larynx, a modified videofluoroscopic swallowing function study including lateral, A-P view with an esophageal scan, a nasopharngoscopy with endoscope. I understand that I am having difficulty swallowing and that this procedure may lead to changes in my diet and feeding status. This risks and benefits of this test have been explained to me.

- **I request that either payment of authorized insurance benefits be made to me or on my behalf to MBS Advantage, Inc. for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.**
- **I request payment of authorized secondary benefits be made to this provider. I authorize any holder of medical information about me to release to my secondary insurance any information needed to determine these benefits.**

❖ **PLEASE PRINT PATIENTS NAME: _____ DOB: _____**

_____	_____	_____
Signature of Patient or Surrogate Decision Maker	**Date**	**Relationship to Patient/Legal authority**

➔ **IF THE RESPONSIBLE PARTY IS UNAVAILABLE TO SIGN AUTHORIZATION IN PERSON AND YOU ARE OBTAINING TEMPORARY VERBAL AUTHORIZATION, YOU MUST OBTAIN A COMPLETED AUTHORIZATION FORM SIGNED BY THE RESPONSIBLE PARTY AND SEND IT TO US *WITHIN TEN DAYS* OF THE MBS BEING PREFORMED. FAXED COPIES OF RESPONSIBLE PARTY'S SIGNATURE ARE ACCEPTABLE.**

Phone Authorization taken by _____,
EMPLOYEE NAME EMPLOYEE TITLE

On _____ at _____am / pm. Verbal consent was obtained from Surrogate Decision-
DATE TIME

Maker: _____ the Patient's _____,
NAME RELATIONSHIP

who is available by phone or mail at: _____.

FOR PRACTICE USE ONLY **(**Failure to obtain consent-check appropriate reason**)**

□ Indirect Treatment Relationship □ Substantial Communication Barrier □ Refusal to Sign □ Other: _____

_____	_____	_____	_____
PRACTICE SIGNATURE	DATE	WITNESS SIGNATURE	DATE