



TREATMENT CONSENT FORM

I authorize Swallowing Diagnostics, LLC to perform the Fiberoptic Endoscopic Evaluation of Swallowing (FEES) procedure on the following Medicaid patient:

Name: _____
(Please print clearly)

Facility Name: _____
(Please print clearly)

I acknowledge that although a Medicaid patient, the procedures performed on the above named must be paid for in full by my facility within the agreed upon terms outlined in the signed contract.

Printed Name & Title

Date

Signature

SDX Therapist Signature

SWALLOWING DIAGNOSTICS, LLC

P.O. Box 484 · AVON, CT 06001

(860) 677-4048 PHONE/FAX

KATRINA@SWALLOWINGDIAGNOSTICS.NET