# Dynamic Medical Solutions, Inc.

3500 S. Boulevard, Suite 18 B
Edmond, OK 73013

# PATIENT AUTHORIZATION

I hereby grant permission for Dynamic Medical Solutions, Inc. to administer barium for the purpose of diagnosing abnormalities of the swallowing function as well as the thoracic esophagus and cervical spine.

I further authorize the release of any and all information required by Dynamic Medical Solutions, Inc., for services furnished me in order to process insurance claims in my behalf.

In consideration of services rendered or to be rendered, I hereby irrecoverably assign and transfer mentioned policies of insurance. I hereby authorize the insurance carrier(s) to pay directly to Dynamic Medical Solutions, Inc., for all charges in excess of the sums actually paid pursuant to said policies.

A photostatic copy of this ***Patient Authorization*** form shall be considered as effective and valid as the original.

I also hereby agree to pay for any and all emergency medical services dispatched by Dynamic Medical Solutions, Inc., on my behalf whether utilized or refused by me.

Resident's Name: _____

Print Name of Signer: _____

Signature of Resident or Responsible Party: _____

Verbal Consent Received From: _____

Date: _____ / _____ / _____

Witness: _____ Date: _____ / _____ / _____