BIRJIS K. ALAM, M.D., P.A.

12781 Miramar Parkway, Suite 101
Miramar, FL 33027

PATIENT NAME: ____________________________________

CONSENT FOR DIAGNOSTIC, PRESCRIPTION HISTORY AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize the physician and any other health professional as designated to perform a physical examination and routine diagnostic procedure upon me, I also, consent to and authorize the physician and any other health professional to view my prescription history from external sources and to prescribe a therapeutic regime which I shall follow.

Patient signature:__________________________ Date:_____________

REFERRAL POLICY

If a patient is currently contracted with an insurance company that requires a referral to either a specialist, diagnostic facility, therapy facility or for durable medical equipment, the following protocol shall be followed to ensure all urgent referrals are done first and foremost, then all others in order according to medical need and date seen or date referral was requested.

- "Dr-determined" referral of **emergent** necessity- issued same day
- "Dr- determined" referral of **urgent** necessity- 24 hour time limit
- Routine referral request by either physician, specialist or patient- These requests will be addressed within 5-10 business days of request.

Patient signature:__________________________ Date:_____________

NO SHOW POLICY

We understand that there are reason for having to cancel an appointment, we ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a $35.00 cancellation fee.

Patient signature:__________________________ Date:_____________