NORTH DALLAS INTERNAL MEDICINE

JEB S. MIERS, M.D.

DIPLOMATES OF THE AMERICAN BOARD OF INTERNAL MEDICINE

NOTICE OF INSURANCE VERIFICATION AND REFERRALS

I ______________________, the patient, understand that as the consumer of the insurance company, it is my responsibility to verify that my physician is "in network" according to my insurance plan(s) and notify the office of any changes in my insurance coverage. Furthermore it is my responsibility to obtain referrals needed prior to the date of service and ensure my referrals are current on date and number of visitations. If I am seen "out of network" and/or without a referral, I understand my insurance company may not pay for services rendered, and I will be liable for all charges incurred.

X_______________________________ _________________________ ________

Patient Name Printed Patient Signature Date

PATIENT PORTAL ACTIVATION

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, view current scheduled appointments, request medication refills, request referrals to specialists, complete medical questionnaires, view summaries of your recent visits and more. In order to activate this functionality for you personally, we MUST have an active e-mail address associated with your account. Please list your e-mail address here: ____@_________ We will activate your account today and you will receive and e-mail within 24-48 hours with your login information.

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize this office to have access to my prescription drug history. I understand this authorization allows this office to obtain my prescription history electronically from retail pharmacies.

__________________________ X_______________________________ ___________________

Patient Name Printed Patient Signature Date

AUTHORIZATION OF DISCLOSURE

I__________________, the patient, authorize the full disclosure of my entire medical record including but not limited to patient histories, office notes, test results, radiology studies, films, studies, consults, alcohol/drug treatment, mental health information, HIV-related information, billing records, insurance records, and records sent by other physicians to the following individuals and or physicians:

______________________ _________________________ _______________________

Name of Individual Relationship to patient Contact number

______________________ _________________________ _______________________

Name of Individual Relationship to patient Contact number

8210 Walnut Hill Lane Suite 812 Dallas, TX 75231 Phone 214-696-1118 Fax 214-696-4447

NORTH DALLAS INTERNAL MEDICINE

JEB S. MIERS, M.D.

DIPLOMATES OF THE AMERICAN BOARD OF INTERNAL MEDICINE

______________________ ________________________ ______________________

Name of Individual Relationship to patient Contact number

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of the disclosure. Information re-disclosed by the recipients listed in this authorization will not be the liability of the physicians. Authorization may be revoked in part or in full at any time with written authorization by the patient.

_________________________ X_____________________________ __________________

Patient Name Printed Patient Signature Date

This authorization is given freely with the understanding that: 1. I may revoke this authorization in writing at any time, but not retroactively. 2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

NOTICE OF CHARGE FOR MISSED APPOINTMENTS

Due to the increasing number of missed appointments, our office will charge a $25.00 fee for a missed appointment existing patients and $50.00 for new patients appointments that is not cancelled 24 hours prior to the appointment time. I acknowledge this policy:

_________________________ X_____________________________ __________________

Patient Name Printed Patient Signature Date

8210 Walnut Hill Lane Suite 812 Dallas, TX 75231 Phone 214-696-1118 Fax 214-696-4447