Jimmy D. Schmidt, M.D.
819 Peakwood Dr.
Houston, TX 77090

PATIENT MEDICAL CONSENT FORM

1. Consent to Medical Treatment/Authorization to Release Information

I (for) undersigned patient, do hereby voluntarily consent to such physician care involving routine diagnostic procedures and medical treatment by my physician; his/her assistants; or designees. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during the visit. I further authorize DermSurgery Associates to release to the insurers herein specified, or to any agency concerned with the payment of my medical charges, any and all information (including copies of records) relating to the visit.

2. Medicare Patients Certification (Medicare ONLY)

I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

3. Responsibility of Non-Covered Services

I have been informed that the medical procedures, treatments, and services provided to me are furnished only at my direction or at the direction of my physician and that DermSurgery Associates makes no representation concerning the medical necessity or reasonableness of such procedures, treatments, or services. The decision as to the necessity or reasonableness of any procedure, treatment, or services is made by the appropriate state medical program, insurance company, or its health insurance agent. I understand that I am responsible for payment for any procedures, treatment, or services, which were provided to me at my request, and which may be determined not to be medically necessary ass required by the appropriate government or insurance medical program.

4. Assignment of Insurance Benefits Distribution of Overpayment/Obligation of Guarantor

Each of the undersigned hereby authorizes all (his/her) insurers, whether or not specified, to make payments of insurance benefits directly to DermSurgery Associates rather than to said undersigned, but such payments shall not exceed DermSurgery Associates regular charges. The undersigned recognizes, however, that (he/she) remains financially responsible to DermSurgery Associates for charges not paid or covered by said insurers. Each of the undersigned insureds also hereby authorize any overpayment to DermSurgery Associates regarding each visit which would otherwise be payable to said undersigned to be applied and credited against any balance due to DermSurgery Associates for which said undersigned is the responsible party. I, the undersigned guarantor, hereby guarantee full and prompt payment to DermSurgery Associates of all charges made as a result of services rendered during any visit. The patient is responsible for any legal or court cost required in the collection of any unpaid accounts.

_____ _____

Patient/Insured/Guarantor Date