David E. Schmidt Jr., M.D.
Delaware Plastic and Reconstructive Surgery

This is to certify that I am personally liable and responsible to Dr. Schmidt for the bills incurred in providing me medical services and that I will provide this office with all the necessary information concerning my health insurance and will authorize my insurance carrier to pay him directly. I understand that if a particular service is not covered under my contract, they will deny payment for that service and I will be billed for the service(s). I also understand that an interest of 1.5% per month will be charged for unpaid balances after 60 days. We will not become involved in disputes between you and your insurance regarding deductibles, co-payment, covered charges other than to supply factual information as necessary. Payment is due upon receipt of the bill.

Self-Pay: If you do not have insurance, payment in full is expected at the time of visit. We accept Visa/Master Card/ Discover/American express.

Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

1. _____
2. _____

Calls: Please indicate below if you want to receive calls about your appointments, results or other healthcare information (circle below):

At Home Yes/No (circle) At Work Yes/No (circle) Leave Message Yes/No (circle)

Contact through Email address **Yes/NO** _____ (email)

Reschedule: If you are unable to keep your appointment, please notify us at least 24 hours in advance should you want to reschedule. Failure to do so will result in a $25 fee for regular office appointments and $50 fee for surgery appointments.

_____ _____
Witness Patient

_____
Date