Dr. Jennifer Schmidt
40900 Merchants Ln, Ste 202 **Phone: 1-888-775-2525**
Leonardtown MD 20650 **Fax: 301-769-6446**

Patient Informed Consent for Medical Treatment – page 1

I, _____, D.O.B._____ (patient or legal guardian) by signing the following document certify that I have read and understand all risks and responsibilities as outlined by this agreement.

I understand that I am giving Dr. Jennifer Schmidt consent to act as a medical consultant or advisor. If Dr. Schmidt is acting as my primary care physician she is doing so in a limited capacity. I understand that she may not have the equipment or supplies to provide a full range of primary care services to me at this time. If she is not able to provide certain services to me then she will refer me to a provider or facility that can provide these services.

I ALSO UNDERSTAND THAT DR. SCHMIDT WILL NOT BE AVAILABLE 24 HOURS A DAY OR EVERY DAY OF THE WEEK. IF I HAVE ANY URGENT MEDICAL QUESTIONS AFTER BUSINESS HOURS OR I EXPERIENCE ANY SEVERE OR POTENTIALLY LIFE THREATENING SYMPTOMS SUCH AS CHEST PAIN, SHORTNESS OF BREATH, CONFUSION, HIGH FEVER, HEADACHE, ABDOMINAL PAIN, INABILITY TO SPEAK, WEAKNESS OR ANY OTHER SYMPTOMS THAT ARE CAUSING ME DISTRESS, I WILL CALL 911 OR SEEK CARE AT THE NEAREST EMERGENCY ROOM.
Initial_____

As a fully licensed physician Dr. Schmidt may prescribe certain medications in a manner that is not consistent with their approved use by the U.S. Food and Drug Administration. Dr. Schmidt may also prescribe medications at higher doses and for longer time periods than they are FDA approved. I understand that the use of any medication carries a certain degree of risk and all potential side effects or future harm cannot be predicted. I fully accept the inherent risk in using medications in hopes that they will provide greater benefit to me than harm.
Initial_____

Dr. Jennifer Schmidt
40900 Merchants In. Ste 202 **Phone: 1-888-775-2525**
Leonardtown MD 20650 **Fax: 301-769-6446**

Patient Informed Consent for Medical Treatment – page 2

I agree to take any medications in the manner in which they were prescribed and I agree to report any potential side effects that I may be experiencing from the use of these medications as soon as reasonably possible. I also understand it is my responsibility to provide Dr. Schmidt with a complete and up to date list of medications (including over the counter), allergies, and health problems that may potentially impact my medical care.
Initial_____

I agree that I am voluntarily participating in all activities prescribed or recommended by Dr. Schmidt and I assume all risks of injury, illness or death. I also understand that Dr. Schmidt is not offering any guarantees of my immediate or future success in meeting my health care goals.
Initial_____

Financial Agreement

By signing below I understand that I am entering into a contractual agreement to pay Dr. Schmidt for her services on a cash only basis. Dr. Schmidt will not bill my medical insurance company for her services but when requested will provide copies of her consultative notes directly to me. I understand that I am solely responsible to submit the required paperwork and copies of bills to my insurance company if I am attempting to get reimbursement for payment through a Health Savings Account or other reimbursement program.
Initial_____

I have read and fully understand this consent form and I realize that I should not sign this form if I have any questions regarding the nature of the services provided, the inherent risk of any medical treatment or my financial obligation in paying for these services.

Patient (or Guardian for minors)
Signature_____Date:_____
Patient Printed Name_____D.O.B._____

Dr. Jennifer Schmidt's Signature_____Date:_____