SHAWNA DEEVES M.D.

4211 GARDENDALE ST. SUITE A200
SAN ANTONIO TX, 78229
(210) 714-0066
FAX: (210) 888-1449

CONSENT FOR TREATMENT

I authorize and request my provider to carry out evaluations, treatment and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that I may terminate treatment at any time. While the course of treatment is designed to be helpful, I understand that there is no assurance that I will feel better, and my provider can make no guarantees about the outcome of my treatment. Because treatment is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed which may be upsetting in nature and that may be necessary to resolve my problem(s).

____
Patient/Guardian Signature

____
Patient Name

____
Date

GENERAL CONSENT FOR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize Shawna Deeves M.D. to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

____
Guardian Signature

____
Patient Name

____
Date