SHAWNA DEEVES M.D.

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

INSURANCE ACKNOWLEDGMENT

INSURANCE AUTHORIZATION:
I hereby authorize SHAWNA DEEVES M.D. and/or the CLINIC staff to furnish information to my insurance carrier(s) concerning the treatment or condition of myself or my dependents.

AS**SIGNMENT OF BENEFITS:**
I hereby assign to SHAWNA DEEVES M.D. all payments for mental health care, medical treatment and/or healthcare services that SHAWNA DEEVES, M.D. and/or the CLINIC provides to me and/or my dependents. I understand that I am financially responsible for any amount not covered by insurance.

STATEMENT OF FINANCIAL RESPONSIBILITY:
I understand I that I am financially responsible for the payment of all amounts incurred for the professional care, treatment and services that SHAWNA DEEVES, M.D. and/or the CLINIC provides to me and/or my dependents.

I understand that SHAWNA DEEVES, M.D. and/or the CLINIC is authorized to bill my insurance directly for such professional care, treatment and healthcare services in addition to collecting payments from me for any copays, deductibles and/or services provided to me and/or my dependents not covered by insurance.

If the insurance company fails to fully pay SHAWNA DEEVES, M.D. and/or the CLINIC for professional care, treatment and/or healthcare services provided to me and/or my dependents for any reason, I understand that I am financially responsible for the payment of any unpaid amount(s) not paid by insurance .

I understand that I am also financially responsible for the payment of any insurance copayments and/or deductibles applicable to the professional care, treatment and/or healthcare services provided by SHAWNA DEEVES, M.D. and/or the CLINIC to me and/or my dependents and that full payment for such services is due one day in advance of each scheduled appointment with SHAWNA DEEVES, M.D. and/or the CLINIC unless otherwise agreed in writing signed by SHAWNA DEEVES, M.D.

By my signature below, I hereby agree to pay SHAWNA DEEVES, M.D. and/or the CLINIC for such professional mental health care, medical treatment and healthcare services as SHAWNA DEEVES, M.D, the treating provider, provides to me and/or my dependent(s) in accordance with the Insurance Authorization, Assignment of Benefits and Statement of Financial Responsibility set forth above.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

A COPY (FRONT AND BACK) OF YOUR INSURANCE CARD AND ID MUST BE FAXED TO (210) 888-1449 OR EMAILED TO ADMIN1@SHAWNADEEVESMD.COM

SHAWNA DEEVES M.D.

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

ID and Insurance Card Instructions

You will need to do this prior to your next appointment with Dr. Deeves.

Patients with insurance:

Please send a copy/ photo of your ID card and a copy/photo of the front and back of your insurance card to admin1@shawnadeevesmd.com

Patients without insurance / self pay:

Please send a copy/ photo of your ID to admin1@shawnadeevesmd.com

Signature:_____ _____

DATE

Signed By:_____