SHAWNA DEEVES M.D.

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

Policies and Procedures

Please read the following and Sign in the space provided.

LOCATION AND HOURS:

Our office is located at 4211 Gardendale St. Suite A200, San Antonio TX 78229. You can call the Clinic at (210)714-0066. Office hours are Monday through Thursday, 9:30 a.m. to 4:30 p.m. and closed from 11:30 a.m. to 12:30 p.m. for lunch and Friday Office hours are from 9:30 to 12:30 p.m. Appointment times are available Monday through Friday between the hours of 9:00 a.m. to 5:00 p.m.

EMERGENCIES: I have coverage for emergencies after hours and on weekends. Please use this for emergencies only. In the event of an emergency, you may call **(210)576-5335** and follow the directions to contact me. THE PATIENT PORTAL IS NOT FOR EMERGENCIES.

APPOINTMENTS:

Scheduled appointment times are reserved especially for you. If you cannot make it to your appointment, please let us know in advance so that we can schedule that time for someone else. You may cancel a scheduled appointment up to 2 business days prior to the scheduled appointment time by calling the office directly and speaking to a member of my administrative staff with no penalty or charge.
We will be conducting most sessions in person, however should the pandemic warrant a change in this we will then do sessions via Telemedicine methods. Initial intakes and paperwork appointments will be conducted in person at the office. Telemedicine sessions may be requested provided you have no outstanding balance, all clinic paperwork is completed and agree to have your payment method processed the morning of your session.

MISSED APPOINTMENTS / CANCELLATIONS / TARDINESS:

It is very important to come to your appointment and be on time. I strive to keep the sessions as close to the appointment time as possible. If a patient is running late, they must contact the office staff as soon as possible to discuss if they will be able to be worked into the schedule that day, of if they will need to reschedule on a later date. A patient arriving late may be considered a "No Show". If an appointment is missed or canceled with less than 2 business days prior notice, you may be billed a $100 No Show Fee.

PROVIDER CANCELLATIONS:

Occasionally I may need to change my schedule, cancel, and reschedule appointments with you. You will be informed of this as far in advance as possible. In the event of illness, I may unfortunately be forced to give you little or no notice regarding the absence and the need to reschedule your appointment.

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Clinic Policies & Procedures

PAYMENTS AND BILLING:

Payment is expected at the time of your appointment. My contracts and agreements with insurance companies and health plans require me to collect all co-payments and deductible amounts at the time of service. If you feel there are extenuating circumstances surrounding the missed or late canceled appointment you may contact my office. If we are conducting your visits via Tele-Medicine, it is suggested to put a form of payment on file. This will expedite the payment process and shorten the time you will need to spend on the phone. You can also make your payment through the Patient Portal. A receipt will be sent to you if requested.

CREDIT CARD POLICY

We have implemented a credit card policy where we obtain your credit card information which will be kept securely in your file until your insurance(s) have paid their portion of your bill and notifies us of the balance due, if any. At that time, I will send you a statement and you will have 30 days to pay. After 30 days, if your bill remains unpaid, we will bill your credit card for the amount due. You will still be able to dispute a charge or question your insurance company's determination of payment.

SPECIAL DOCUMENTATION AND LETTERS:

In order to better serve you, FMLA paperwork must be filled out during a scheduled in person appointment. It is important that you be there for your input on some of the questions, and to be aware of the treatment plan and contents of this paperwork. If you need a letter for any other reason, I require a seven-day advance notice.

PATIENT PORTAL AND DOCUMENTATION:

All patients are required to have an active Patient Portal. This is one of the methods we will use to communicate with you. The patient portal is the preferred place to sign the Practice Paperwork. You will need to input a credit card into your Card Manager in your Portal. If you do not have access to a PC you can download the documents on my website and return them either by mail or faxing them to my office. The fax number is (210) 888-1449. You are also welcome to stop by the clinic during business hours to complete the forms. **THE PATIENT PORTAL IS NOT FOR EMERGENCIES OR REFILLS.**

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PRESCRIPTIONS AND REFILLS:

All Refills must be initiated by you by calling our office. No other method is authorized.
Practice Documents are required to be completed for any prescriptions or refills will be released.
Prescriptions are generally written in a quantity to last until the next scheduled appointment. Please fill your prescriptions promptly. Controlled substance prescriptions are valid for 21 days. If it becomes necessary for a refill to be called in due to you not keeping a scheduled appointment, a charge of $20.00 may be assessed. **A charge of $20.00 will be applied to prescriptions and triplicate medications that are written between appointments.** A $30.00 charge will be applied if a prescription must be rewritten due to the loss or expiration of that prescription.

Requests for prescription refills are to be called into my office from Monday through Wednesday for approval. A minimum of **five working day**s is typically required for the prescription refill to be approved. Prescription refills cannot be ordered or approved after business hours because your chart may not be available. Controlled substance prescriptions that are stolen require an appointment and a police report to be replaced / refilled. Stimulant prescriptions are not refilled outside of an appointment.

Prior Authorizations may take up to seven days and a charge of $25.00 will be assessed for this service.

YOUR MEDICAL RECORDS:

If you would like another physician or other professional to obtain a copy of your record, a release of information must be signed. The requesting party will be responsible for any fees. When applicable, the charge for records is $25.00 for the first 20 pages and .50 cents for each additional page after the first twenty. All fees must be paid in advance. It may take up to 15 business days to obtain a copy of your medical records once all fees are paid.

CLINIC TREATMENT PHILOSOPHY:

Treatment goal or goals will be established after a thorough assessment. It is very important to be completely honest with the answers to the questions asked. You are asked to take an active role in setting and achieving your treatment goals. Your commitment to treatment and cooperation is necessary for you to experience a successful outcome. This may include proper use of prescribed medications. If you have any questions about the nature of your treatment or care, please do not hesitate to ask.

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PATIENT RIGHTS AND RESPONSIBILITY:

1. You have the right to receive information about my services and qualifications, clinical guidelines, and patients' rights and responsibilities.

2. You have the right to be treated with respect, recognition of your dignity and need for privacy.

3. You have the right to participate fully in decision-making regarding your treatment planning.

4. You have the right to voice complaints or appeals about the care provided to you.

5. You have the responsibility to provide, to the extent possible, all information that I need in order to care for you. This includes all medication, alcohol and drug use.

6. You have the responsibility to follow the plans and instructions for care that you have agreed upon.

7. You have the responsibility to participate, to the degree possible, in understanding your behavioral health problem(s) and developing mutually agreed upon treatment goals.

8. Aggressive or threatening behavior either physical, written, or verbal will not be tolerated and may be grounds for terminating your treatment at my clinic.

ACKNOWLEDGMENTS

By signing this document, I hereby acknowledge that I have received, read, and fully understand the policies and procedures associated with SHAWNA DEEVES M.D. and/or the CLINIC as set forth above. SHAWNA DEEVES and/or the CLINIC have explained the each of above policies and procedures to me and answered any questions I had for clarification I hereby agree to follow all the above policies and procedures while am a patient of SHAWNA DEEVES M.D.

SIGN NAME: _____

PRINT NAME: _____

DATE: _____

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SHAWNA DEEVES M.D.

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Clinic Telemedicine Policies & Agreement

Our clinic conducts in person sessions; however, we will provide Telemedicine Sessions upon request or as needed due to the ongoing public health crisis situation with COVID 19. The following criteria must be met in order to have a Telemedicine Session. Please review the items below and initial them accordingly and sign and date in the space provided.

Telemedicine Requirements

Initial the following in the space provided.

_____All practice paperwork must be completed. This includes a completed Patient Packet and a copy of your insurance card and ID on file.

_____A credit / debit card on file in your Credit Card Manager within your Patient Portal. (We can help you with inputting that information into the system.)

_____You must have a zero balance on all past appointments.

Clinic Telemedicine Agreement

I hereby agree to follow the above requirements and authorize the Clinic Staff to charge the card on file in the Credit Card Manager within in the patient portal on the day of my session. I understand that I will be charged any of the following that may be applicable to my session: Co-Pay, Co-Insurance, Unmet-Deductible or combination thereof. I also agree to being charged the Clinics NO-SHOW fee should I miss my appointment / session without prior approval / notice given as per the Clinic Policies already set forth in the Practice Policies and Procedures. (Please review these at our website www.ShawnaDeevesMD.com for more information.)

_____

Patient Name

_____ _____

Sign Here **Date**

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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

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SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

Privacy Practices: We are required by law to follow the practices described below. This is a summary of our Privacy Practices but does not replace the full version which will be made available to you upon request. This notice applies to personal medical/health information that we have about you, and which are kept in or by SHAWNA DEEVES, M.D. and/or the CLINIC. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, or wish to file a complaint, please contact the office staff of SHAWNA DEEVES, M.D. and/or the CLINIC at 210-714-0066 Mondays through Thursdays between 9 a.m. to 3 p.m. CST.

Medical/health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. My clinic will only release as little information as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third-party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer services to patients.

We may use your personal information without your permission:

- To make appointment reminders.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To exchange information with other State agencies as required by law.
- To inform you about possible treatment options.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- To respond to or refute online comments / reviews.

SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES CONT.

We may use your personal information without your permission:

- As required by State, Federal, or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroners, medical examiners, and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

You have the right:

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete. You must make this request in writing. We may deny your request if: We did not create the entry that is wrong; or the information is not part of the file we keep; or the information is not part of the file that we would let you see; or we believe the record is accurate and complete.
- To know to whom, we have sent information about you for up to the last six years. The first request in a 12-month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example, not to release information to your spouse or a particular provider agency. (This must be made in writing, and we are not required to agree to the request).
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made inwriting.
- To tell us (authorize) other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).
- To have a paper copy of the Notice of Privacy Practices.
- To file a complaint if you believe any of your rights have been violated. All complaints must be in writing. You will not be penalized if you file a complaint.
- I have read and agree to the HIPPAA Privacy Practices / Policies as listed above.

_____

Patient/Guardian Signature

_____

Patient Name

_____

Date

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Authorization for Release of Confidential Information

Patient Name: _____

DOB: _____ SS#: _____

_____ I ***decline*** to give authorization to release information at this time.

_____ I ***authorize*** SHAWNA DEEVES M.D. and/or the CLINIC staff to disclose the following health information about me:

_____ All Information/Records

_____ Evaluation/Consultation Reports

_____ Progress Notes

_____ Billing Records

_____ Other _____

The information to be disclosed is from_____ to ____present/_____ (dates).

This information may be disclosed to (please give name and address of recipient):

Name: _____

Address: _____

_____

Phone / Fax: _____

2. This information may be disclosed for the purpose of:
_____ Coordination of Care
_____ Assistance/Support of Treatment
_____ Other _____

5. The information may be disclosed until (ending date) _____. If this date is left blank, the authorization will automatically expire one year from the date I sign below.

INITIAL_____

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Authorization for Release of Confidential Information

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SHAWNA DEEVES M.D. and/or the CLINIC staff from all liability arising from the disclosure of my Health information.

I understand that I may inspect, or request copies of any information disclosed by this authorization.

I understand that I may revoke this authorization by notifying, in writing, SHAWNA DEEVES M.D. and/or the CLINIC except to the extent that action has already been taken on it.

I understand that I may decline to give authorization and that declining authorization to release information will not affect my ability to obtain treatment, payment, or my eligibility for benefits from SHAWNA DEEVES M.D. and/or the CLINIC.

NAME: _____

Patient Signature _____
Guardian Signature if appropriate Relationship to Patient

Date: _____

SHAWNA DEEVES M.D.

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PATIENT AUTHORIZATION FOR PAYMENT

I hereby agree to pay my treating provider, SHAWNA DEEVES, M.D, and/or the CLINIC for all professional mental health care, medical treatment and healthcare services provided to me and/or my dependent(s). I further consent to receive such professional mental health care, medical treatment and healthcare services, as deemed necessary by SHAWNA DEEVES, M.D, and/or the CLINIC, including treatment with medications.

Payments from Health Insurance
I authorize SHAWNA DEEVES, M.D, and/or the CLINIC, to bill my insurance for professional mental health care, medical treatment and healthcare services that SHAWNA DEEVES M.D. and/or the CLINIC provides to me and/or my dependents.

Payments from Patients for Copays, Deductibles and/or Non-Covered Services
I hereby understand and agree to pay SHAWNA DEEVES M.D. and/or the CLINIC for all copays, deductibles, and/or healthcare services provided to me and/or my dependents that are not covered by my insurance on the date payment is due. **I UNDERSTAND AND AGREE THAT MY PAYMENTS FOR COPAYS, DEDUCTIBLES AND/OR NON-COVERED SERVICES ARE DUE AND PAYABLE ON THE DAY BEFORE EACH SCHEDULED APPOINTMENT WITH SHAWNA DEEVES, M.D. and/or the CLINIC.**

Credit Card Authorization
By signing below, I hereby authorize SHAWNA DEEVES, M.D, and/or the CLINIC to keep my signature and my credit card information securely on-file in my account and to charge my credit card for the unpaid balance due for copays, deductibles and/or services not covered by my insurance on the date such payment is due

Credit Card Information
My credit card information is: Visa □ MasterCard □ Discover □ American Express □
Patient's Name (Print): _____ DOB: ___/___/_____
Name on Card (Print): _____
Last Four Digits of Credit Card Number: _____ Exp. Date: ___/____
If Applicable, Please fill out information below for any other person(s) you authorize this credit card for:
Patient Full Name (Print): _____ DOB: ___/___/_____
Credit Card Holder's Signature: _____ Date: _____

Credit Card Authorization Also Applicable to Replacement Cards
If the above credit card changes, expires, or is denied for any reason, I agree to immediately provide SHAWNA DEEVES, M.D, and/or the CLINIC with a new, valid credit card and authorize SHAWNA DEEVES, M.D, and/or the CLINIC to charge the new credit card for copays, deductibles and non-covered services on the date those payments are due using this same authorization I am signing below

_____
Patient/Guardian Signature

_____
Patient Name

_____
Date

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PATIENT INFORMATION SHEET

Please fill out completely. If a section does not apply, write N/A

Patient'sName:_____
Last Name First Name Middle Initial

Patient's Address:_____
Street Address City State Zip

Phone: _____ Email:_____

Patient's DOB: _____ Patient's SSN: _____ ☐Male ☐ Female

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐ Other _____

Patient's Driver's License #/State: _____

Emergency Contact: _____ Relationship: _____

Contact Phone: _____

Preferred Pharmacy Name: _____

Pharmacy Phone: _____

Primary Care Physician: _____

PCP Phone: _____

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INSURANCE INFORMATION SHEET

1. PRIMARY INSURANCE CO. NAME: _____

   EFFECTIVE DATE: _____

   POLICY/Member ID NO.: _____

   GROUP NO.: _____

NAME OF POLICY HOLDER: _____

Relationship to Patient: □ Self □ Spouse □ Dependent/Child □ Other

POLICY HOLDER'S SSN: _____

POLICY HOLDER'S D.O.B.: _____

2. SECONDARY INSURANCE CO. NAME _____

   EFFECTIVE DATE: _____

   POLICY/Member ID NO.: _____

   GROUP NO.: _____

NAME OF POLICY HOLDER: _____

Relationship to Patient: □ Self □ Spouse □ Dependent/Child □ Other

POLICY HOLDER'S SSN: _____

POLICY HOLDER'S D.O.B.: _____

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

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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

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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:_____