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 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 processes 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.

INITIALS_____

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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 one of the methods we will use to communicate with you. The patient portal is the preferred place to sign the Practice Paperwork. 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.

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PRESCRIPTIONS AND REFILLS:

All Refills must be initiated by you via a telephone. 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 days 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 may 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. and the CLINIC

SIGN NAME: _____

PRINT NAME: _____

DATE: _____

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