SHAWNA DEEVES M.D.

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

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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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