Robin May-Davis Psychiatry

1114 Lost Creek #320 Austin TX 78746

Patient Name: _____ Date of birth: _____

Consent to treatment

By signing this consent I agree to work with Dr. Robin May-Davis or her assistants and designees as is necessary in her judgment. She is to provide me with medical care, including evaluation, consultation, and/or treatment.

Patient signature: _____ Today's date _____

Receipt of office policies and financial agreement /No Surprises

By signing this form I acknowledge that I have received and reviewed the office policies of Dr. Robin May-Davis and have had an opportunity to inquire about these. I understand payment is due to time of session unless prior arrangements have been made. I am responsible for payment, co-pay, and all non-covered services. I have received and reviewed her copy of No Surprises billing.

Patient Signature: _____ Today's date _____

Privacy Practices Acknowledgement

I have received the notice of Privacy Practices and have been provided an opportunity to review it.

Patient signature: _____ Today's date _____