Robin May-Davis Psychiatry P.A.

2224 Walsh Tarlton Lane #110 Austin TX 78746

Consent to treatment

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

Patient signature: _____ Date of birth: _____ Today's date _____

Receipt of office policies and financial agreement

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 inquired 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 authorize my payment for any medical benefit to Robin May-Davis, MD by third party agencies for services provided and medical records can be sent as necessary to process claims.

Patient Signature: _____ Date of birth: _____ Today's date _____

Privacy Practices Acknowledgement

I have received the notice of Privacy Practices (Effective 5-15-15)and have been provided an opportunity to review it.

Patient signature: _____ Today's date _____

Patient Name: _____ Date of birth: _____

Address: _____

City: _____, TX Zip code : _____