Consent to Coaching Session with Dr. Richard Shames

I, _____, fully understand that this form constitutes my agreement to purchase health coaching session from Richard Shames MD. I agree to work directly and regularly with a primary care doctor in my local vicinity, who will manage my ongoing medical care. I understand that Dr. Shames' health coaching services do not replace individual medical care in any way, but instead constitute a health education opportunity - not the diagnosis and treatment of an illness**. I understand that Dr. Shames is not available for questions except during scheduled follow-up phone appointments.**

I further agree that at the time of faxing this form, with my credit card number and signature on it, my credit card will be charged (either $270 for Initial Coaching-50 minutes or $170 for a Follow-up Coaching-25 minutes) to hold an appointment slot for me, and that I then **call** 415-472-2343 between 9am-5pm (PST) to schedule the exact time of the appointment **(Coaching Sessions are scheduled for Mondays or Tuesdays)**. It is further understood that should I need to later change my appointment time, I will have one opportunity only to reschedule without a fee, as long as I have called to reschedule more than 48 hours in advance (2 business days). (You must cancel by am Thursday for Monday appt and am Friday for Tuesday appointment. **I understand that once my form is faxed and my credit card charged, there will be no refunds, only possible re-schedules.**

I understand that I will also be able to fax a **maximum of six (6) pages of lab results**, to be reviewed by Dr. Shames. PLEASE FAX THESE PAGES TOGETHER WITH YOUR AGREEMENT; THEY MUST BE RECEIVED BY WED. PRIOR TO YOUR PHONE APPT. I understand that if I for some reason I miss my scheduled discussion appointment, or have to cancel with less than 48 hours notice, I am still liable for the $270 fee. I will call to reschedule another appointment within 3 months of my scheduled appointment, and understand that while every effort will be made to secure a 25-minute makeup session, there is no guarantee that I will be able to be scheduled without having to pay for another coaching session.

I understand that Dr. Shames is not available for questions except during scheduled follow-up phone appointments. I also understand that lab tests must be ordered by my local doctor for any possible insurance reimbursement - Dr. Shames cannot sign any insurance forms related to coaching. I understand that by signing this contract, I am bound to pay for informational educational services only, and will so do and submit to the jurisdiction of the State of California where the information is disseminated. I have supplied a witness signature, my credit card number, as well as my own signature below. This contract may only be enforced against persons and entities associated with Shames Family Services in the State of California, County of Marin, and under the internal laws of the state of CA. This constitutes the complete contract between me and Shames Family Services for telephone discussion only. Nothing in our e-mail communications nor in our web pages should be construed as medical diagnosis or treatment. No doctor-patient relationship is established by these e-mail or telephone contacts. I agree to consult with my own doctor for diagnosis and treatment specific to my particular case. For a full disclaimer, see: http://www.feelingfff.com/disclaimer.html

To schedule your session, fill out the Coaching Session Request Form below. All lines must be filled in below, and must have a witness signature to be processed. Fax it to: 415-472-7636. Then call 415-472-2343 between 9am-5pm (PST) to schedule a Monday/Tuesday appointment for your coaching session with Dr. Shames. **YOU** will be given a phone number for **YOU** to call Dr. Shames at your appointment time! **NO MEDICARE BILLING OR REIMBURSEMENT IS POSSIBLE.**

_____ _____

Print Name Signature and Date

_____

Print Witness Name Witness Signature and Date

_____

Your Street Address: City State Zip

_____

Home Phone Work Phone Cell Phone Fax

_____

Best Times to Reach You Email Address Birth Date

_____

Type of Card Credit Card Number Expiration Date

_____

Print Formal Name on Card Signature of Card Holder-if different from "coachee": __

_____

How did you hear about Dr. Shames?

_____

Name of Your Primary Doctor Doctor's City, State Phone #

PLEASE FAX ENTIRE AGREEMENT TO 415-472-7636

Then call (415) 472-2343 to schedule time