In-Person Medical Office Visit With Dr. Richard Shames
PATIENT CONSENT

I, ______________________________________, understand that this form constitutes my agreement
(print name)
to purchase hormone-balancing medical care from Richard Shames MD.

I agree to be also working with a primary care doctor, who will manage my general health needs.

I understand that at the time of faxing or emailing this form:
my credit card number and signature are included,
my credit card will be charged $345 for the 50-minute New Patient session,
or charged $210 for the 25-minute revisit,
with no refund available.

I understand that a New Patient 50-minute session will be scheduled and the time held for me
after this consent form has been received by the scheduling coordinator
and I then call 415-472-2343 to schedule the exact time of the appointment
(you may call and speak with the scheduling coordinator from 9am-5pm)
Medical office visits are scheduled
for Tuesdays at the medical office in Cotati, CA
or Wednesdays & Thursdays at the PMCM medical offices in San Rafael, CA.

It is further understood that should I need to change my appointment time after scheduling,
I must provide at least 48 hours advance notice.
Late cancellation or missed appointments will result in the loss of the appointment fee,
except in dire emergency.
With at least 48 hours advance notice we will be happy to rearrange your appointment.

Medical Office Visit Request

All lines must be filled in, including witness signature AND primary physician information in order for this form to be processed. Scan it and then email it to Julie@pmcmarin.com or Fax it to: 415-472-7636.
Then call 415-472-2343 between 9am-5pm (PST) to schedule a Tues - Wed - Thur
in–person office appointment with Dr. Shames. **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 ______________________

Best Times to reach you Email Address Birth Date ______________________ Cell Phone ______________________

Credit Card Number Expiration Date 3 Digit Security Code ______________________

Name as Printed on Card Signature of Card Holder-if different from patient ______________________

How did you hear about Dr. Shames? ______________________

Name of Your Primary Doctor Doctor’s City, State, & Phone # ______________________

PLEASE SCAN and THEN EMAIL ENTIRE AGREEMENT to Julie@pmcmarin.com
OR FAX TO (415) 472-7636, then call (415) 472-2343 to schedule your desired time