Consent to In-Person Office Visit with KARILEE Shames, PhD. RN

I, _____, understand that this form constitutes my agreement to purchase a health promotion in-person office visit with Karilee Shames PhD, RN, Certified Holistic Nurse. I understand that Karilee provides counseling, support, education, and energetic interventions for health promotion, and that these services in no way replace medical treatment. I agree to be also working with a primary care doctor, who will manage my general health needs**. I understand that Karilee Shames is not available for questions except during scheduled follow-up in-office or scheduled phone consultations.**

I understand that at the time of faxing this form, with my credit card number and signature on it, my credit card will be charged $150 with no refund available for the New Patient 50-minute session 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 **(Karilee's in-office visits are generally scheduled for Wednesdays, with some flexibility possible)**. 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 loss of the appointment fee, except in dire emergency. With at least 48 hours advance notice we will be happy to rearrange your appointment to suits your needs. We look forward to supporting your health goals.

To schedule your session, simply fill out the Karilee Shames In- Office Visit Request Form below. All lines must be filled in, including witness signature AND primary physician information in order for this form to be processed. **Fax it to: 415-472-7636**. Then **call 415-472-2343** between 9am-5pm (PST) to schedule a Wednesday in–person office appointment with Dr. Karilee 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 Work Phone Cell Phone Fax

_____

Best Times to reach you Email Address Birth Date

Type of Card (MC/Visa only) Credit Card Number Expiration Date

_____

Print Formal Name on Card Signature of Card Holder-if different from patient

_____

How did you hear about our work?

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