Action Potential
One on One Physical Therapy

Client Name: _____ DOB: _____

Statement of Client Consent for a Virtual Visit Consultation

Action Potential, LLC, is pleased to provide you with access to physical therapy screening through a virtual visit consultation. Virtual visit physical therapy screening is intended to provide you with information regarding your current condition and the recommended steps to alleviate your issue, and is not a full medical evaluation. Given the results of your screen, a more thorough evaluation may be necessary. Virtual visit screening is a non-covered service through your medical health insurance provider, therefore it will not be submitted for insurance coverage. Participation in a virtual visit consult is voluntary and will not be provided through a HIPAA secure portal.

If the services you have elected to receive imply a financial responsibility on your part, payment is paid on a cash basis and is due in full prior to the scheduled screening.

Consent to Treatment

_____**(initial)** I hereby consent to a virtual visit consult (screening) by the therapists at Action Potential, LLC.

_____**(initial)** I consent that information regarding my care may be communicated via voicemail/text and/or email.

_____**(initial)** I acknowledge that a virtual visit will not be provided through a HIPAA secure portal.

_____**(initial)** I give my permission and would like to be contacted about continued after care programs.

Client Signature: _____ **Date:** _____

Client Representative: _____ **Date:** _____
(If patient is a minor, or if authorized by patient)