Action Potential
One on One Physical Therapy

Client Name: _____ DOB: _____

Statement of Client Consent for a Virtual Visit Treatment

Action Potential, LLC, is pleased to provide you with access to physical therapy treatment through a virtual visit. Virtual visit physical therapy treatment is intended to provide you with treatment for your current condition from a virtual location. Virtual visit treatments may be a non-covered service through your medical health insurance provider. If your insurance covers virtual visits, we will submit for payment on your behalf. If you insurance does not cover this service, you may elect to pay out of pocket.

If the services you have elected to receive imply a financial responsibility on your part, payment is paid with cash or credit card and is due in full prior to the scheduled session.

Consent to Treatment

_____**(initial)** I hereby consent to a virtual visit treatment 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, if covered, my treatment will be submitted to my insurance carrier.

_____**(initial)** I acknowledge that, if not covered, I am responsible for payment of this non-covered service.

Client Signature: _____ **Date:** _____

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