



I consent to participating in a telehealth visit with a Physical Therapist, who is an employee of Revive Physical Therapy. I understand that the evaluation and treatment of current medical condition(s) using a video and/or audio call is under the Physical Therapy scope of practice similar to a clinic visit and will be carried out by a licensed physical therapist.

I understand the Physical Therapist will conduct the session in a space that is conducive for keeping health information private and maintain professional guidelines. I understand that no physical exam or manual therapy will be given during a telehealth visit and I agree to the Therapist's plan of care that may be modified for telehealth.

I have also signed the general consent form for treatment from the clinic, Revive Physical Therapy. The current clinic policies apply to telehealth visits as well.

I understand that this telehealth visit will be billed to my insurance and I will be responsible if my insurance does not cover it.

***I have read and agree to all the policies on this form***

***Patient Name:*** \_\_\_\_\_

***Patient Signature:*** \_\_\_\_\_

***Date:*** \_\_\_\_\_