**Athletic Potential: Performance Physical Therapy**
Athletic Potential: Performance Physical Therapy, Kent, WA, 98032
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# Telehealth Consent Form

## Athletic Potential Performance Physical Therapy, LLC

**We ask all patients to sign this form in the event you choose to receive any or all evaluations and treatments via Telehealth either now or on a future date. Telehealth services will not be rendered until this has been signed and returned.**

- ☐ I hereby consent, by my own free will, to voluntarily engage in the virtual/ telehealth session, through telephone or video conferencing (Zoom, PTEverywhere or any other video platform). If the patient to be seen is a minor, with my signature below I acknowledge that I am the parent and/or legal guardian of the minor and I am providing consent for them. I understand and acknowledge that I have the right to be present during the virtual/ telehealth visit and will select my preference below. I understand and acknowledge that If I select below to require myself to be present on the video call, and I am absent, then Dylan Newcomer, DPT and/or Athletic Potential Performance Physical Therapy, LLC must oblige and discontinue the video call unless granted permission in writing, in advance, in order to continue. I understand and acknowledge that I will not receive a refund if I failed to inform Dylan Newcomer, DPT and/or Athletic Potential Performance Physical Therapy, LLC of my absence prior to the start of the video call and my absence led to the termination of the video call and no services being rendered for the scheduled visit.
- ☐ I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist (Dylan Newcomer, DPT and/or Athletic Potential Performance Physical Therapy, LLC). I understand that the physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment.
- ☐ I understand that recommendations will be made by my therapist, based on the findings in this session, for improvement of my pain and overall wellness. I understand that I may be directed through specific activities, exercises and/ or movements as instructed by my therapist. I am aware that my physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.
- ☐ I have been informed and understand that during my participation in any sessions, I will be responsible for honestly reporting any symptoms I may have, such as pain, fatigue, shortness of breath, pain or ANY other findings.
- ☐ I know that it is my right to stop any activity at any time, during any session, as well as it being my obligation to inform the therapist of any symptoms, should any develop (as indicated above).
- ☐ I understand that my therapist will make every effort to address my symptoms, functional deficits (if any) and concerns and that the goal is for total alleviation of symptoms and/ or improvement of function. However, I acknowledge that no guarantee has been provided of changes or improvements in my symptoms or condition.
- ☐ I recognize that these sessions will allow me to learn ways to move better, feel better and teach me techniques and skills that I can utilize independently on a daily basis and improve my quality of life

☐ I am aware that addressing my symptoms or diagnosis may take a few sessions and I am required to closely follow all provided instructions to have the best chance for successful outcomes.

☐ I understand that the number of sessions will vary based on the primary complaints and symptoms and that while there may be an estimated number of sessions provided to address an issue, there is no guarantee any issue will be resolved.

☐ I understand that I am 100% responsible for payment, due at time of scheduling. NO insurance in any form will be billed, charged or collected for these sessions. I choose by my own free will to participate and invest in this service. I may request an invoice (superbill) to be submitted to my insurance for reimbursement but I acknowledge that I am provided with no guarantee that my insurance will reimburse me for any or all of the services rendered.

☐ In taking part in these sessions, via phone or video platform, I acknowledge that I am fully responsible for any and all risks, injuries, or damages, known or unknown, which might occur as a result of my participation.

**By signing below, I hereby WAIVE AND RELEASE Athletic Potential Performance Physical Therapy, LLC, its owners, officers, employees, and instructors from any claim, demand, cause of action of any kind resulting from or related to my participation in the online/ telehealth sessions.**

**Patient Name**

**Patient Signature (or Parent and/or Legal Guardian Signature)**

**Please use your mouse or finger to draw your signature below**

**Date**

◉ I am representing the minor to be seen on the video call and require my attendance for the entirety of the video call.

○ I am representing the minor to be seen on the video call and DO NOT require my attendance for part of or the entirety of the video call.

○ I am the patient to be seen, and attest I am 18 years or older