



## Understanding and Waiver of Physical Exam

Patient's Name (*printed*): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZipCode: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### UNDERSTANDING AND CONSENT

*By signing below I understand that by the very nature of a phone or Skype consultation, that the clinician providing the consultative services is unable to perform a physical exam on a patient.*

*Physical exams can reveal to the clinician important information about the patient and the patient's condition. I understand that it is not possible to perform a physical exam during a phone or Skype consultation. I agree to furnish the name and phone number of my physicians and a copy of my most recent physical exam performed by one of my physicians. I understand that this information must be received by your office before the time and date of the phone or Skype consultation.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**By typing in your name above, you agree that all the information provided is truthful and accurate and legally binding.**

\_\_\_\_\_  
Name