



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