ADVANCE PHYSICAL THERAPY
CERTIFIED POSTURAL RESTORATION CENTER
77 South Elliott Road, Chapel Hill, NC 27514 phone 919.932.7266 fax 919.932.7250

NON-COVERED SERVICES WAIVER FOR TELETHERAPY AND CONSENT FOR TELETHERAPY TREATMENT

Your insurance company reserves the right to decide what services are medically necessary for you and which health related services they will cover. Services which are acceptable to your insurance company are labeled "covered benefits." Services which they will not cover are labeled as "non-covered services."

Advance Physical Therapy is now offering teletherapy treatment options which may not be covered by your insurance company. For example, physical therapists can connect with patients through an online platform to deliver patient education, create or review care plans, and ensure patient success in performance of therapeutic activities.

If your insurance company denies coverage of teletherapy sessions, labeling them as "non-covered services" or "medically not necessary" you have the option to self-pay for this service, at the following rates:

TELETHERAPY RATES:

Teletherapy Treatment Rate (for existing and new patients): $25 per 15 minutes
New Patient Teletherapy Initial Encounter: $150 for 1 hour
New Patient Teletherapy Screening: $75.00 for 30 minutes

I acknowledge that I have been informed in advance of receiving teletherapy services, that these services may not be covered by my health insurance plan. I have chosen to receive these services, and understand that I will be financially responsible for the services not covered by my health insurance plan, which will be billed at the rates listed above.

_____

Patient Name

_____ _____

Signature of Patient (or Legal Guardian) Date

CONSENT FOR TELETHERAPY TREATMENT

I, the undersigned, give permission to the practitioner/s of Advance Physical Therapy, to administer evaluation and treatment necessary and advisable for my condition via teletherapy. If patient is a minor, a parent or guardian must sign. Consent must be signed before we begin teletherapy treatment.

_____ _____

Signature of Patient (or Legal Guardian) Date

*This form must be signed by the patient or legal guardian **PRIOR** to patient receiving any non-covered service(s) or item(s), and must be maintained in the patient's medical record.*