Chapel Hill Scoliosis and Postural Restoration Center
77 South Elliott Road, Chapel Hill, NC 27514 phone 919.932.7266 fax 919.932.7250

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.*