FELLOWSHIP
REHAB & WELLNESS
Back to Health. Back to Life.

9000 Fellowship Road
Basking Ridge, NJ 07920

I,_____ acknowledge _____ will be
Patient's Representative *Patient's Name*
receiving a private pay health and wellness program provided by Fellowship Rehabilitation & Wellness. This program is not skilled in nature and is not reimbursable by Medicare/insurance. It is a program that will be paid privately and is based on a rate of $20.00 per 15 minutes of time.

Fellowship Rehabilitation & Wellness recommends a frequency of _____ days per week. Estimated weekly charges are _____.

You will receive an invoice on a monthly basis and this amount will need to be paid within 30 days to Fellowship Senior Living.

_____
Responsible Party Signature

_____
Date