



FELLOWSHIP

REHAB & WELLNESS

Back to Health. Back to Life.

HEALTH & WELLNESS PROGRAM CONSENT/ACKNOWLEDGMENT FORM

Resident Name: _____

Consent for Program and Patient Bill of Rights

I authorize Fellowship Village Rehab to conduct the health and wellness program as a compliment to my overall wellness goals. I agree to work with them on mutually established health and wellness goals, which have been cleared by my physician.

Health and Wellness- Start of Care Date: _____

I warrant that I have read the Consent for this program above and have received a copy of the Patient Bill of Rights.

Signature: _____ Date: _____
(Patient/Patient's Representative)

If any of the above is signed by an authorized representative due to the incapacity of the Patient, what is the relationship of this representative to the patient? _____

Please specify the time in minutes you would like your family member to participate:

15 mins per session, _____ times per week.

30 mins per session, _____ times per week.

45 mins per session, _____ times per week.

60 mins per session, _____ times per week.

Other: (Please indicate): _____

Signature: _____ Date: _____

The fee is \$20.00 per 15 minutes segment, which in many cases will reflect a lower rate than the previous Medicare or insurance billing models.