Patient ID:

MOBILE REHAB
FINANCIAL POLICY

Patient:	ID #:	Group #:
Primary Insurance:	Effective Date:	Spoke To:
Authorized for:	Pre-cert Instructions:	

We have verified your insurance coverage and benefits as of _____. This information is being provided to you exactly as it was told to us. Please INITIAL highlighted benefits related to your policy.

	You do not have a co-pay associated with your primary insurance.
	You do not have a deductible associated with your primary insurance.
	You do not have a co-insurance associated with your primary insurance.
	You have a secondary insurance with Aetna. Your benefits are as follows: _____. Your estimated responsibility will be _____.
	We accept Cash, Personal Checks, and Credit Cards (MASTERCARD, VISA, DISCOVER).

Please be aware that your benefits and/or coverage information may be subject to errors. Therefore, we strongly recommend you contact your insurance directly if you have any questions or concerns regarding this benefit.

If there are concerns regarding your financial responsibility for this service, please ask the Front Office to speak with our Billing Department at (619) 434-9800 to discuss your situation if needed.

CONSENT: I understand these benefits as explained to me.

Patient Signature: Date:

Mobile Rehab Employee Signature: Date: