California Rehabilitation, Inc.
L. Scott Stoney, M.D.
361 Hospital Road, Suite 425
Newport Beach, CA 92663
(949) 548-4580 / FAX (949) 548-2558

WAIVER FORM

Patient Name:______________________________________ Patient Account #:______________

Patient Date of Birth:_______________________________ Patient SSN #:______-____-______

Patient Address:____
Street, Apt #

____
City, State Zip Code

I, __________________________, understand and agree that if my insurance denies the services
(Patient's Name)

provided to me from California Rehabilitation, Inc., I will be held financially responsible for payment of all services rendered.

____ ________________________
Signature of Patient of Responsible Party Date

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Print Name of Patient of Legal Guardian