Participation Agreement

Comprehensive Pain Center

1. We request payment or co-payment and a valid referral form for services at the time service is rendered. If you require a procedure, we will file an insurance claim on your behalf. We will bill you for the portion of the fee that is not covered by your insurance. I hereby authorize the Comprehensive Pain Center to apply on my behalf for covered services rendered. I request payment from my insurance carrier(s) of record be made directly to the Comprehensive Pain Center. I certify that I have reported correctly with regard to my insurance coverage and further authorize the release of any necessary information, including medical information for this or related claims to my insurance carrier(s) of record. I permit a copy of this authorization to be used in place of the original.

2. I will arrive to my appointments ten minutes early to allow time for check-in. If more than **15 min late**, my appointment may be rescheduled, and with no notification, I may be charged a missed appointment fee ($50 for an office visit, $75 for a procedure). I will be responsible for obtaining my referrals for my office visits and procedures. If I do not have my referral(s)/approval(s), I may not be able to see the practitioner. If I do need to reschedule, **24-hour notification is required.** Appointment reminder phone calls are not made by Comprehensive Pain Center.

3. I will comply with the recommended diagnostic evaluations, therapeutic interventions and ongoing recommendations for optimal medical care outcomes. I understand that weight management is an essential and crucial aspect of my treatment plan and failure to comply with weight management plans.

4. I will be responsible for financial obligations which will include co-pays, fees and other charges. They are due prior to the visit with the Comprehensive Pain Center practitioner. I realize I may not be permitted to continue with the care of the Comprehensive Pain Center if I am not responsible with my financial liabilities. I will provide all necessary information to bill my insurance company and keep the Comprehensive Pain Center informed about any changes in insurance coverage.
    a. **Self-Pay Rates**: Initial Office Consult $500; Follow-up $200; Procedure $400
    b. **Medical Records**: $21.18 (prep fee) + 73¢ per page + Shipping
    c. **Medical Forms / Opinions**: $300 (not part of typical treatment)

5. I will restrict phone calls and messages to normal office hours. I will not call for non-emergencies on evenings or weekends. If I do have a medical emergency, I will go the ER and have the ER doctor phone the Comprehensive Pain Center as indicated. I will notify the Comprehensive Pain Center of any narcotic prescriptions that I may obtain from the hospital visit.

6. I give permission for the Comprehensive Pain Center to take photographs of me for identification purposes only. I also give consent to have my photo taken if my pain condition would benefit from monitoring the treatment with photographs. These photographs will be for the use of the Comprehensive Pain Center only.

Printed Name		Signature		Date

Medical Pavilion at Howard County
10710 Charter Drive Suite 240
Columbia, MD 21044

P: 410.997.PAIN (7246)
F: 410.997.7226
info@comprehensivepaincenter.net
www.ComprehensivePainCenter.net

Stanford Overlook
8894 Stanford Overlook Suite 104
Columbia, MD 21045