I, _____certify that I
(print name)
am not currently involved in a Workman's Comp or Auto claim. I also declare that my health insurance will be my primary method of payment while a patient of Comprehensive Pain Management. If at any time should that information change, I must notify Comprehensive Pain Management of that change. If I fail to do so, I will be solely responsible for any and all charges that I incur.

Signature: _____

Date: _____