COLUMBIA CLINIC
Pain & Ortho-Spine Institute

2700 S. Rochester Rd.
Rochester Hills, MI 48337
Phone: 248-212-0777
Fax: 248-575-4144

Dear Patient,

By signing the following you hereby agree to comply with the upcoming appointments that were scheduled as a part of your treatment plan.

Further to consent that you agree to follow the scheduling protocol for these appointments by:

1. Calling within 15 minutes before your scheduled appointment, if you are running late.
2. Calling within 24hrs for the cancelation of any follow up appointment.
3. Calling 5 days in advance for rescheduling a procedure appointment.

I _____ agree to follow the scheduling protocol as explained and I understand that failure to comply with set protocol will result in a $35 fee for a clinic visit and $150 fee for a procedure appointment.

Patient Signature: _____ Date: _____

Usama A. Gabr, MD, FAAPMR

Acknowledged: _____
Medical Director