



LINCOLN.B. PAIN CLINIC, LTD.

COMPASSIONATE PAIN MANAGEMENT.

600 N. North Court, Suite 200, Palatine, IL 60067

I, the undersigned patient or guarantor, release Lincoln B. Pain Clinic, LTD and all affiliated physicians from any and all responsibility for charges for office visits, X-rays, lab work or any other testing procedure for which I have not obtained authorization or referral from my primary care physician, or have not used the designated facility required by my insurance company.

Signature: _____ Date: ____/____/____
(Signature of Patient or Guarantor)