LINCOLN.B. PAIN CLINIC, LTD.

COMPASSIONATE PAIN MANAGEMENT.

INTERVENTIONAL SPINE & JOINT CARE·
PHYSICAL MEDICINE & REHABILITATION·
600 N· COURT, SUITE 200
PALATINE, IL 60067·

Edward Babigumira, M·D·
Pain Management Agreement·

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines and discharge me from the clinic.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, heroin, etc.

I will not share or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine form loss or theft, Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use_____Pharmacy.
Located at _____,
Telephone number _____ for filling prescriptions of all my pain medicine.

I authorize the doctor, and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood, cheek swab or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I agree that I will not operate heavy equipment or drive under the influence of narcotics.

I will bring all unused pain medicine to the office every visit.

I will submit to random pill counts anytime my physician deems necessary.

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____, _____
Patient Signature: _____
Physician Signature:_____
Witnessed By:_____