



ILBNC, P.A.

Institute for Low Back and Neck Care

ILBNC Special Procedures

Corporate address

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## NARCOTIC MEDICATION POLICY

If your physician at the Institute for Low Back and Neck Care is prescribing opioid/narcotic pain medication as part of your treatment plan, please understand the following:

- Our goal is to assist you with pain control and improved function at the lowest effective dose of pain medication.
- These medications are part of a treatment program and cannot be renewed if the other aspects of the program are not pursued.
- These medications need to be taken exactly as prescribed by your doctor. These medication prescriptions should come from only one physician and should be filled at the same pharmacy.
- Narcotic medications will only be refilled by your treating physician's service at ILBNC.
- Your medications are your responsibility, lost or stolen narcotics will not be replaced.
- **YOU SHOULD EXPECT A RANDOM URINE ANALYSIS.** Dependant upon your health insurance this could be at your own expense.
- Excessive use, misuse or abuse of these medications will necessitate stopping the prescribing altogether.
- We require **three business days'** notice to refill any prescription. There will be no weekend or on-call refills of narcotics.
- **We will not accommodate medication on a walk-in basis. For refills, patients are responsible for contacting their pharmacy which will then contact us. Even if your bottle says "no refills" you are to call your pharmacy.**
- We will manage post-surgical pain for up to three months after surgery.
- We will not prescribe narcotic medications for longer than one month's time, if not a surgical patient.
- If your treatment consists solely of narcotic medications, you will be referred to your primary physician or a physician who specializes in the medical management of chronic pain.

Your preferred pharmacy name: \_\_\_\_\_

Pharmacy telephone number: \_\_\_\_\_

Pharmacy city: \_\_\_\_\_

We greatly appreciate your active participation in your care!

*Institute for Low Back and Neck Care Medical Staff*

Please sign below to indicate that you have read the above agreement.

\_\_\_\_\_  
(Patient signature)

\_\_\_\_\_  
(Print patient name)

Date: \_\_\_\_\_