Priti Modi M.D.,F.A.C.P
Pinnacle Health Center
1608 Tully Road
Modesto, CA 95350

Controlled Substance Contract

This agreement relates to my use of controlled substances for chronic pain prescribed by a physician. I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at Dr. Modi, M.D. office. I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:

1. I will use the substances **only** as directed by my physician.
2. I will receive controlled substances only from my doctor. Information that I have received controlled substances outside my doctor's office will lead to **discontinuation** of treatment.
3. If my medications have been lost or stolen I am allowed only 2 early refills per year. **NO EXCEPTIONS.**
4. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.
5. I agree to schedule and keep my appointment to continue treatment regimen.
6. I agree to use one pharmacy for filling all prescriptions, except in emergency.
7. I agree to submit to **URINE** and **BLOOD** screens to detect the use of prescribed and non-prescribed drugs.
8. I understand that I am responsible for keeping track of my medication and need to plan ahead for arranging the refill in a timely matter, so I will not run out (2 business days).
9. I understand that if there is any incident regarding the controlled substance it may be reported to other healthcare providers and pharmacies. Also depending on the situation may report to the local **police department** and/or **Drug Enforcement Agency**.
10. I agree to actively participate in all aspects of my pain management program to maximize my functioning and improve my coping with my condition.

By signing below I indicate that I understand and agree to all the terms of the above contract and I may receive a copy of this for my records if requested.

Print Patient Name:______________________________ Date:______________
Patient Signature:______________________________
Physician: Dr. Priti Modi, M.D. Date:______________