**Perez Neurology**
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# Controlled Substances Form

Patient Information:
Name: _____
Date of Birth: _____

I, the undersigned patient, hereby acknowledge and agree to the following terms and responsibilities regarding the prescription and use of controlled substances by [Name of Medical Practice]:

1. Prescription of Controlled Substances:
   - I understand that controlled substances, including but not limited to opioids, benzodiazepines, and stimulants, may be prescribed for the treatment of certain medical conditions.
   - I acknowledge that controlled substances have potential risks, including addiction, dependence, and overdose, and will only use them as prescribed by my healthcare provider.

2. Informed Consent:
   - I have been informed of the risks, benefits, and alternatives of controlled substances and understand the importance of discussing any concerns or questions with my healthcare provider.
   - I agree to provide accurate information about my medical history, including any history of substance abuse, mental health disorders, or concurrent medications.

3. Compliance with Treatment Plan:
   - I agree to follow the treatment plan outlined by my healthcare provider, including adhering to the prescribed dosage, frequency, and duration of controlled substances.
   - I understand that misuse, diversion, or sharing of controlled substances is strictly prohibited and may result in termination of treatment and reporting to appropriate authorities.

4. Monitoring and Follow-Up:
   - I consent to periodic monitoring and follow-up appointments to assess the effectiveness of treatment, monitor for side effects or adverse reactions, and evaluate compliance with the treatment plan.
   - I understand that my healthcare provider may require urine drug screening or other monitoring measures to ensure safe and appropriate use of controlled substances.

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5. Risks and Side Effects:
- I acknowledge that controlled substances may cause side effects, including drowsiness, dizziness, nausea, constipation, and respiratory depression, and will promptly report any adverse reactions to my healthcare provider.

6. Safe Storage and Disposal:
- I agree to store controlled substances securely to prevent unauthorized access or theft and to dispose of unused or expired medications properly in accordance with local regulations and guidelines.

7. Communication:
- I understand the importance of open and honest communication with my healthcare provider regarding any changes in my condition, medication effectiveness, or concerns about controlled substances.

8. Agreement to Terms:
- By signing below, I acknowledge that I have read and understand the terms and responsibilities outlined in this form. I agree to abide by these terms and accept responsibility for the safe and appropriate use of controlled substances.

Patient Signature: _____ Date: _____

Witness (Medical Practice Representative) Signature: _____ Date: _____

Please retain a copy of this form for your records. If you have any questions or concerns regarding these terms, please do not hesitate to contact our office.

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