3425 Colonnade Parkway Suite B, Birmingham, Al 35243
Tel (205) 203-4501, Fax (205) 677-0840

CENTENNIAL NEUROLOGY AND HEADACHE CENTER, PLLC

HECTOR CABALLERO, M.D.

Centennial Neurology and Headache Center
24 Hour Appointment Cancellation Policy

Centennial Neurology and Headache Center, PLLC has a 24 hour cancellation/rescheduling policy. **If an appointment is missed, cancelled or changed with less than 24 hours notice, there will be a $65 charge.** In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Caballero's office promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Centennial Neurology and Headache Center, PLLC as described above. Thank you for your understanding and cooperation.

Signature_____ Date_____

To cancel your appointment, please call 205-203-4501. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call.

HECTOR CABALLERO, M.D.

Centennial Neurology

REGISTRATION INFORMATION

Date: _____ Referring Physician: _____ Pharmacy_____

Pharmacy#_____

Please print legibly

Last Name: First Name: Middle Name: Sex: M / F

Date of Birth: Social Security Number:

Street Address: City: State: Zip:

Mailing Address: City: State: Zip:

Home Phone: Cell Phone: Email Address:

Emergency Contact: Phone:

Marital Status:

Single Married Divorced Widowed

Employer_____

Address_____

Phone: _____

Race: Preferred Language:

Primary Insurance: _____

Policy #_____ Group #_____

Policy Holders Name_____

DOB: _____ SSN: _____

Relation to Patient: _____

Address: _____

Secondary Insurance: _____

Policy #_____ Group: _____

Policy Holders Name_____

DOB: _____ SSN: _____

Relation to Patient: _____

Address: _____

I request and authorize Centennial Neurology to release health information of above patient to:

Name of your primary care physician: _____

Centennial Neurology and Headache Center, PLLC

Hector Caballero, M.D.

NAME_____ DATE_____

REASON FOR YOUR VISIT (CHIEF COMPLAINT):

_____

_____

_____

_____

HOW CAN WE HELP YOU:_____

_____

_____

_____

SOCIAL HISTORY: M S D W Number of children:_____

WORK HISTORY: Employed Unemployed Student Retired Disabled (reason) _____

SMOKING: Never In the past Currently How much?_____

ALCOHOL: Never In the past Currently How much?_____

RECREATIONAL DRUGS: Never In the past Currently What type?_____

PAST MEDICAL AND SURGICAL HISTORY: Circle yes or no as it applies.

Hypertension (High blood pressure) Y N

Diabetes Y N

Coronary Disease Y N

Myocardial Infarction Y N

Gastric Bypass Y N

Asthma Y N

COPD Y N

Gout Y N

Arthritis Y N

Cancer Y N

Location & Yr. Diagnosed _____

Cardiac Bypass Y N

Carotid Surgery Y N

Stents Y N Year_____

Neck surgery Y N Year_____

Thyroid disease (hyper / hypo) Y N

Atrial Fibrillation Y N

Peripheral Vascular Disease Y N

Cancer Surgery Y N

Brain Surgery Y N Year _____

Previous Stroke Y N Year _____

HIV/AIDS (circle one if applies)

Sexually Transmitted Diseases Y N

FAMILY HISTORY:

RELATIVE	LIVING/DECEASED	AGE	CURRENT ILLNESS/CAUSE OF DEATH
FATHER:			
MOTHER:			
SIBLINGS:			

Centennial Neurology and Headache Center, PLLC

Hector Caballero, M.D.

LIST ALL YOUR MEDICATIONS

MEDICATION	STRENGTH	FREQUENCY

DRUG ALLERGIES:

Were you involved in an accident? _____ Date of accident? _____

If yes, what type of accident? _____

Are you disabled? _____ If yes, Cause of your disability? _____

If not, are you seeking disability? _____ If so describe: _____

Centennial Neurology **Hector Caballero, M.D.**

Patient's Name: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I consent to the use or disclosure of my protected health information (PHI) by Centennial Neurology (the company) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I have reviewed a copy of the Company's Notice of Privacy Practices. The notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the company.

The company reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I consent for examination and treatment necessary or desirable to the care of the patient first mentioned above, including, but not restricted to, whatever medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, his nurse or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them at the time of service. I understand that the charges made for professional services may not be covered in full by insurance, although insurance may be filed. I understand that the patient or the responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment, I agree to pay all costs of collection, including a reasonable attorney fee.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment.

FORMS POLICY

I agree to pay administrative fees associated with the completion of generation of forms and other correspondence related to my medical records that are not accomplished at the time of an office visit. These forms include but are not limited to disability papers, letters to insurance companies, medical leave forms and copies of medical record documents. I understand that copies of medical records will include a collation fee along with a fee per page.

_____ _____

Patient's Signature Date

_____ _____

Name of Patient's Representative (if applicable) Date

_____ _____

Signature of Patient's Representative (if applicable) Date

Please List anyone that we can release your medical records/ or information to other than yourself below and include the person's name, relationship, and a phone number.

1._____

2._____

3._____

CAN WE LEAVE MESSAGES ABOUT FOLLOW UP APPOINTMENTS?

YES _____ *NO* _____

I the undersigned, authorize Centennial Neurology to furnish all my medical reports contained in my medical file, such as, but not limited to, my medical history, examination, laboratory test, treatment, diagnosis, prognosis and any other medical records contained in my medical file. I agree to the release of any current or background medical information of any current or previous diseases and treatments that are contained in my medical file.

I further authorize the physician of Centennial Neurology to discuss with the above-named entity any history or findings which may have been made or entered as a notation on my medical record. I waive all rights that I may have or claim to have regarding confidentiality of privilege as the patient.

This authorization has been executed knowingly and voluntarily and for the expressed purposed of obtaining my medical records and providing copies of them to the above entity. I agree to hold harmless the above-named entity and their staff for providing the requested information, so long as they provide the documents and information strictly and only to the requested entity mentioned above and to no other parties without the expressed written consent of myself or my legal representative.

Signature: _____ *Date:* _____

Controlled Substance Agreement

Dr. Caballero may in rare circumstances decide to prescribe a controlled substance for the treatment of your pain. Narcotics and other controlled substances that are monitored by the Drug Enforcement Agency (DEA) require written prescription by a physician who is authorized to do so. Dr. Caballero will write the amount of medication that in his best judgment is necessary to treat your condition. By signing this agreement contract, you agree to the following regulations & if breached you are subject to termination from the practice for good. Plus Dr. Caballero reserve the right to stop prescribing narcotic medication at any point in time if he feels you are in anyway being dishonest or abusing the medication or healthcare system period!!!!

The prescriptions I receive are my responsibility once they are placed on my hand. If anything happens to a controlled substance prescription (it is lost, stolen, damaged, etc.), I will not request a replacement prescription to be written or called in. I understand that these medications have the potential for abuse and must be kept in a secure location.

I will follow the prescription schedule\instruction as written by Dr. Caballero, and in doing so, I should never have to request a refill early. I understand that if I use more medication than the prescribed amount, I might be interfering with the treatment plan. No more will be prescribed or called in until the refill date is due or until my next office appointment. If I repeatedly request early refills on my pain medication, I understand that Dr. Caballero may then decide to stop providing that medication entirely.

If I am prescribed narcotic pain medication by Dr. Caballero, I agree to notify him immediately if I am given/prescribed any other narcotic medications from any other physician.

I understand it is my responsibility to inform Dr. Caballero of any past or present drug, tobacco or alcohol use. I understand that I should not drink alcohol while taking controlled substances.

I understand that using controlled substances in an irresponsible manner risks physical dependence upon these substances. I will only take these medications as prescribed by my treating physician.

Controlled substance prescriptions will not be called in or written after office hours by Dr. Caballero or those on call for him.

Controlled drugs may impair mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating any dangerous motorized vehicles or machinery.

I understand that I should not perform such tasks while under the influence of these medications. I understand that if I violate this contract, Dr. Caballero has the right & may decide to terminate our professional relationship.

I understand that Dr. Caballero is under no obligation to continue providing me with medication for acute or chronic pain if he feels that such treatment has not been proven sufficiently effective.

I understand that many medications cause risks of birth defects and pregnancy related complications. I agree to notify my doctor immediately if I believe I am pregnant and to advise him if I change my contraception methods.

Patient_____ Date_____