

Acknowledgement of Privacy Statement, Authorization and Assignments of Benefits

Patients Name (Please print) _____ Date of Birth _____

Guarantor's Name (Please print) _____ Date of Birth _____
(If patient is a minor or dependent)

Privacy Statement

I acknowledge that I have been informed of the Notice of Privacy Practices and the notice is available to me. Upon my request, I will receive a copy of the Notice of Privacy Practices, September 23, 2013 version. I understand that it is my responsibility to read the information provided therein.

Signature: _____ Date: _____
(If patient is a minor dependent, parent or legal guardian must sign)

Release of Medical Information, Appointments and Prescriptions

If patient is a minor or dependent, **all** parents or legal guardians must be listed below.

Should it become necessary, New Mexico Clinical Research & Osteoporosis Center, Inc. physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorized for the above statement regarding appointments and prescriptions. **I understand that if I need to change this information, it is my responsibility to request this in writing.**

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Name: _____ Relationship: _____

Phone No. _____ () Home () Work () Cell

Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)

Financial and Credit Policy

I acknowledge that I have been informed of the Financial and Credit Policy and the policy is available to me upon my request. The policy provides me with information pertaining to co-pays, coinsurance, deductibles, and the statement process for any outstanding balances due on my account. The policy also addresses my responsibility to provide 24-hours notice if I am unable to keep my appointment and the requirement by my insurance company to obtain and provide a doctor's order from my primary care provider for bone density testing. I understand that it is my responsibility to read the information provided therein.

Signature: _____ Date: _____
(If patient is a minor dependent, parent or legal guardian must sign)

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by New Mexico Clinical Research & Osteoporosis Center, Inc. (NMCROC). I request payment of authorized Medicare, Medigap or other health insurance policy benefits for services rendered to me by NMCROC be made on my behalf to NMCROC. I request that payment of government benefits, if applicable, to the party who accepts assignment. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. I understand that I have the right to revoke this agreement in writing.

Signature: _____ Date: _____
(If patient is a minor or dependent, parent or legal guardian must sign)



Patient Name: _____

Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for the service below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the service below.

Services to be Received	Reason Medicare May Not Pay	Estimated Cost:
<input checked="" type="checkbox"/> Bone Density Exam (DXA) <input type="checkbox"/> Vertebral Fracture Assessment (VFA) <input type="checkbox"/> Electrocardiogram (EKG) <input type="checkbox"/> Injection _____ <input type="checkbox"/> Infusion _____ ***Cost of injection & infusion includes the administration of the drug***	<input type="checkbox"/> Not payable within this time period. <input type="checkbox"/> Service never paid due to medically unnecessary. <input type="checkbox"/> Your diagnosis does not support the need for this service. <input type="checkbox"/> This many services are usually not paid. <input checked="" type="checkbox"/> Frequency Limitations for Coverage <input type="checkbox"/> Other Reason _____ _____	<input checked="" type="checkbox"/> Between \$165 + tax <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service (s) or item (s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the _____ DXA _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the _____ DXA _____ listed above, but do not bill Medicare. You may ask to be paid now, as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> OPTION 3. I don't want the _____ DXA _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____	Date: _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Bone Densitometry: Patient History Form

Revised 12/17

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

Name:	DOB:	Date:
Address:	Home Phone:	Cell Phone:

Osteoporosis Risk Factor Assessment

	Yes	No		Yes	No
Are you a postmenopausal woman?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost more than 2 in. height?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hyper (overactive) <input type="checkbox"/> hypo (underactive)		
Have you broken bones since age 40?	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinologist_____		
Does your mother or father have osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any parathyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mother <input type="checkbox"/> Father			<input type="checkbox"/> hyper (overactive) <input type="checkbox"/> hypo (underactive)		
Has your mother or father had a broken hip?	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinologist_____		
<input type="checkbox"/> Mother <input type="checkbox"/> Father At what age?_____			Do you have a high calcium level in your blood?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have inflammatory bowel disease, Crohn's disease, or ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken steroids, such as prednisone, for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have malabsorption problems or celiac disease?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now taking prednisone?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had stomach surgery, such as gastrectomy or stapling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been on chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had anorexia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had bulimia?	<input type="checkbox"/>	<input type="checkbox"/>
Nephrologist_____			Have you had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a paralyzed arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatologist_____			Do you have 3 or more alcohol drinks per day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take anticonvulsant medication, like Dilantin, phenobarb, or Tegretol?	<input type="checkbox"/>	<input type="checkbox"/>			

Do you currently take or have you ever taken the following medications?

	Dose	Date Started	Date Stopped	Reason Stopped
<input type="checkbox"/> Calcium			<input type="checkbox"/> current	
<input type="checkbox"/> Calcium with Vitamin D			<input type="checkbox"/> current	
<input type="checkbox"/> Multivitamin			<input type="checkbox"/> current	
<input type="checkbox"/> Vitamin D			<input type="checkbox"/> current	
<input type="checkbox"/> Estrogen <input type="checkbox"/> patch <input type="checkbox"/> pill <input type="checkbox"/> cream			<input type="checkbox"/> current	
<input type="checkbox"/> Testosterone			<input type="checkbox"/> current	
<input type="checkbox"/> Prednisone			<input type="checkbox"/> current	
<input type="checkbox"/> Fosamax (alendronate)			<input type="checkbox"/> current	
<input type="checkbox"/> Actonel, Atelvia (risedronate)			<input type="checkbox"/> current	
<input type="checkbox"/> Evista (raloxifene)			<input type="checkbox"/> current	
<input type="checkbox"/> Miacalcin, Fortical (calcitonin)			<input type="checkbox"/> current	
<input type="checkbox"/> Forteo (teriparatide)			<input type="checkbox"/> current	
<input type="checkbox"/> Boniva (ibandronate)			<input type="checkbox"/> current	
<input type="checkbox"/> Reclast (zoledronic acid)			<input type="checkbox"/> current	
<input type="checkbox"/> Prolia (denosumab)			<input type="checkbox"/> current	
<input type="checkbox"/> Abaloparatide (tymlos)			<input type="checkbox"/> current	
<input type="checkbox"/> Didronel (etidronate)			<input type="checkbox"/> current	
<input type="checkbox"/> Strontium			<input type="checkbox"/> current	

Please list all other medications you are currently taking. (Write none if none)

Bone Densitometry: Patient History Form

Revised 12/17

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

Name:	Date of Birth:	Today's date:
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Have you ever broken or fractured a bone? Yes No

Which bone?	Age	What happened?
<input type="checkbox"/> right <input type="checkbox"/> left		
<input type="checkbox"/> right <input type="checkbox"/> left		
<input type="checkbox"/> right <input type="checkbox"/> left		
<input type="checkbox"/> right <input type="checkbox"/> left		

Do you exercise regularly? Yes No

Form of exercise	Frequency per week	Length of time per workout

What was your height at age 25? _____ Weight at age 25? _____

Gender Specific Risk Factors

<u>For women only:</u>	<u>For men only:</u>
<p>At what age was your LAST period? _____</p> <p>How did menopause begin?</p> <p><input type="checkbox"/> Natural <input type="checkbox"/> Hysterectomy</p> <p>If you have ever had a hysterectomy, which describes your procedure?</p> <p><input type="checkbox"/> Both ovaries were removed</p> <p><input type="checkbox"/> One ovary still remains</p> <p><input type="checkbox"/> Both ovaries still remain</p> <p>Are you currently having irregular periods?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has there been an episode when your period stopped for a significant amount of time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had phlebitis or blood clots?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had breast cancer?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes- Date diagnosed _____</p> <p><input type="checkbox"/> right <input type="checkbox"/> left</p> <p><input type="checkbox"/> chemo <input type="checkbox"/> radiation <input type="checkbox"/> surgery</p> <p>Have you ever taken or do you currently take Femara (letrozole), Arimidex (anastrozole), Aromasin (exemestane), or Tamoxifen?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? _____</p> <p>Have you had cancer of the...</p> <p><input type="checkbox"/> Ovary (<input type="checkbox"/> right or <input type="checkbox"/> left) <input type="checkbox"/> Uterus <input type="checkbox"/> Cervix <input type="checkbox"/> None</p> <p>If yes- Date diagnosed _____</p> <p><input type="checkbox"/> chemo <input type="checkbox"/> radiation <input type="checkbox"/> surgery</p>	<p>Do you have erectile dysfunction (impotence)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have low testosterone?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had prostate cancer?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes- Date diagnosed _____</p> <p><input type="checkbox"/> chemo <input type="checkbox"/> radiation <input type="checkbox"/> surgery</p> <p>Are you currently receiving hormonal treatments for prostate cancer?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Revised 12/17

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

Name:	Date of Birth:	Today's date:
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Who ordered this bone density test? _____

Shall we fax copies of your report to any other physician? _____

What is the reason for doing this bone density test? _____

Have you had a bone density test before? No Yes When and where? _____

Ethnic Group: Caucasian Hispanic Asian/Pacific Islander African-American Other: _____

Sex _____

May we contact you for possible participation in research studies? Yes No

Are there any details to any of your answers on this questionnaire you feel we should know?

For Official Use

HT				cc:					
WT		L	R	JC	MG	BW	DXA		

Notes