

## 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)



**Other Insurance (Non-Medicare)**

**Beneficiary Liability Waiver of Non-Covered Service**

Patient Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

There is a chance that your insurance company will not pay for the following service(s) described below. Your doctor or other health care provider may recommend you get services more often than your insurance plan does not cover. If this happens, you may have to pay some or all of the costs.

Services to be Received	Reason Insurance May Not Pay:	Estimated Cost:
<input type="checkbox"/> Bone Density Test (DXA)  <input type="checkbox"/> Vertebral Fracture Assessment (VFA)	<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"/> Frequency Limitations for coverage	<input type="checkbox"/> \$165+ tax

Although we may not be required by your insurance plan to provide you with this notice, the purpose of this form is to help you make an informed choice about whether you want to receive these service(s) knowing that you may be responsible for the cost.

- Yes, I want to receive these service(s), and I want to have my insurance billed.
- Yes, I want to receive these service(s), and I **do not** want my insurance billed. I will pay now.
- No, I do not want to receive these service(s).

Most insurance companies may pay for screenings once every 24 months (UnitedHealth Care once every 36 months) and follow national guidelines for determining if the test will be covered. You are responsible for checking the coverage requirements of your insurance plan.

I understand that by signing this form, I will be fully responsible for the above estimated cost if I have elected to receive this service(s). I also understand that it is my choice to have these service(s) provided by New Mexico Clinical Research and Osteoporosis Center.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



# 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)


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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 <b>LAST</b> 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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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  
WT

cc:  
L R JC MG BW DXA

Notes