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)

NEW MEXICO
Clinical Research &
Osteoporosis Center, Inc.

E. Michael Lewiecki, MD, FACP, FACE - Osteoporosis Director
Lance A. Rudolph, MD - Research Director
Julia R. Chavez, CNP - Adult Healthcare
Michelle B. Garcia, PA-C - Adult Healthcare
Becky Wittenburg, CNP, MSN – Adult Healthcare

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:
☒ Bone Density Exam (DXA) ☐ Vertebral Fracture Assessment (VFA) ☐ Electrocardiogram (EKG) ☐ Injection _____ ☐ Infusion _____ ******Cost of injection & infusion includes the administration of the drug******	☐ Not payable within this time period. ☐ Service never paid due to medically unnecessary. ☐ Your diagnosis does not support the need for this service. ☐ This many services are usually not paid. ☒ Frequency Limitations for Coverage ☐ Other Reason _____ _____	☒ **Between $165 + tax** ☐ _____ ☐ _____ ☐ _____ ☐ _____

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.**

☐ **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.

☐ **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**.

☐ **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:**

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.

Accredited by the International Society for Clinical Densitometry for bone densitometry and vertebral fracture assessment

300 Oak St. NE, Albuquerque, NM 87106
Phone 505.855.5525 Fax 505.884.4006
www.nmbonecare.com

OSTEOPOROSIS HISTORY
New Mexico Clinical Research and Osteoporosis Center
Lance Rudolph, MD

GENERAL INFORMATION

Name: _____Date of Birth: _____

Age: _____ Gender: M F (circle) Marital Status: _____

Ethnic background: _____

Are you retired? Y N
Occupation or Prior Occupation_____

Who referred you here? _____
Who is your primary care doctor? _____
Is there anyone else you would like to get a copy of this consultation? _____

How can we help you? _____
_____
_____

DIET AND HABITS

Describe your diet: _____
_____

How many servings of dairy products do you consume per day? _____
(1 serving is a glass of milk, an ounce of cheese, a cup of cottage cheese, or a container of yogurt)

Do you salt your food? Y N

Do you have lactose or dairy intolerance? Y N

Do you exercise? Y N What do you do? _____
_____

How long do you do it? _____ How many days per week? _____

Do you smoke? Y N How many packs per day? _____
If you stopped smoking, how old were you when you stopped? _____
How many years did you smoke? _____

Do you consume alcohol? Y N

How much per week? _____

BROKEN BONES

What bone fractures have you had, how did they happen and how old were you at the time?
_____
_____
_____

STRENGTH AND BALANCE

Have you lost strength? Y N
Do you have problems getting out of a chair? Y N
Do you have balance problems? Y N What kind? _____
_____
_____
Do you use a walking aid or mobility aid? Y N What kind? _____
Have you had a fall? Y N
When was your last fall and what happened? _____
_____
_____

FAMILY HISTORY

Do any of your blood relatives have osteoporosis? Y N Who? _____
_____
Do any of your blood relatives have osteopenia (low bone density)? Y N Who? _____
_____
Has any one in the family had a bone fracture? Y N
(We are particularly interested in hip fractures)

Who, at what age and what type of fracture?
Who_____ Age _____ Type_____
Who_____ Age _____ Type_____
Who_____ Age _____ Type_____

YOUR HISTORY

Are you allergic to any medications? Y N
What medications are you allergic to and what reactions do you have from them?
_____
_____
_____

How tall were you at age 20? _____

If you feel you have lost height, how much? _____

Please circle any of these illnesses that you have had and explain below if necessary:

Osteoporosis	Gastrointestinal disorder
Osteopenia	Esophageal Stricture
Heart disease	Ulcers
Lung disease	Trouble swallowing
Kidney disease	Other GI disorder
Liver disease	Celiac Disease
Transplantation	Endometriosis
Cancer	Asthma
Diabetes	Obesity Surgery (list age and date)
Rheumatoid Arthritis	Other surgery (list age and date)
Thyroid Disease	Hypertension
Kidney Stones	Paget's disease
Stroke or other neurological disorder	Any other significant medical illness?

Explain Here: _____
_____
_____

For Females: Age at Menopause_____
Did you take estrogen? Y N
At what age did you start taking estrogen? _____
When did you stop or are you still on it? _____

For Males: Do you have testosterone deficiency? Y N
Do you have erectile dysfunction? Y N

Do you get regular dental care? Y N

MEDICATION HISTORY

Have you taken medications for osteoporosis or osteopenia? Y N
If so, what medications, when did you start them, when did you stop them, did you have problems with them and if so, what problems? List below:

Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____
Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____
Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____
Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____
Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____
Medication_____ Start_____ Stop_____ Problem Y N What Problem? _____

Additional space to explain problems: _____
_____
_____

Are you taking prednisone or other steroids? Y N
Are you taking drugs to control the immune system? Y N
Are you taking drugs for prostate cancer? Y N
Are you taking antidepressants? Y N
Are you takings medicine for acid reflux or other stomach conditions? Y N

Do you take calcium? Y N What brand? _____
How many milligrams? _____
Do you split the dose? Y N
Do you take the calcium with food? Y N
Does your calcium have vitamin D in it? If so, how much? _____

Do you take extra vitamin D? Y N How much? _____
Do you take a multivitamin? Y N
Do you take strontium? Y N

Please list all your prescription medications (name and dose):
_____
_____
_____
_____
_____

Please list all over the counter supplements other than calcium, vitamin D and multivitamins:
_____
_____
_____

Thank you for filling out this history form. The doctor will fill in any missing details at your visit.