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 Consultation: Patient History Form

New Mexico Clinical Research & Osteoporosis Center *Form revised 12/10*

Patient Name _____ Today's Date _____

Age _____ Sex _____ Ethnic Group: Caucasian ❒ Hispanic ❒ African-American ❒ Other ❒

Occupation or former occupation. _____ Are you retired? _____

Who referred you to us? _____

Who is your primary care physician? _____

To whom shall we send a copy of your consultation report? _____

_____

What is the reason for this consultation?_____

_____

Have you had a bone density test? _____

List the date and place for every bone density test. _____

_____

_____

_____

_____

Have you had X-rays, CT scan, or MRI of your spine? _____

List the date and place of every spine X-ray, CT scan, or MRI. _____

_____

_____

_____

Have you ever had X-ray therapy for any reason? _____

Are you interested in participating in an osteoporosis research study if you qualify? _____

Osteoporosis Risk Factor Assessment

	Yes	No
Have you lost more than 2 in. height?	❒	❒
Have you ever broken a bone? (list your age, date, and circumstances for every fracture below)	❒	❒
Does your mother, father, brother, or sister have osteoporosis?	❒	❒
Has your mother, father, brother, or sister broken bones since age 40?	❒	❒
Do you smoke cigarettes?	❒	❒
Do you have more than two drinks of an alcoholic beverage per day?	❒	❒
Do you weigh less than 127 lbs?	❒	❒
Do you have rheumatoid arthritis?	❒	❒
Do you have kidney failure?	❒	❒
Have you had vitamin D deficiency?	❒	❒
Do you have lactose intolerance?	❒	❒
Any difficulty with digestion?	❒	❒
Have you ever had hyperthyroidism (an overactive thyroid gland)?	❒	❒
Have you had hyperparathyroidism, or a high calcium level in your blood?	❒	❒

	Yes	No
Do you have inflammatory bowel disease, such as Crohn's disease?	❒	❒
Do you have intestinal malabsorption, such as celiac disease?	❒	❒
Have you had a gastrectomy (part of your stomach removed)?	❒	❒
Have you ever had an eating disorder?	❒	❒
Have you had an organ transplant?	❒	❒
Have you fallen in the last year?	❒	❒
Do you have a walking or balance problem?	❒	❒
Do you have to push off on the arms of a chair to stand up?	❒	❒
Do you have any problems with infections or pain in your teeth or jaw?	❒	❒
Do you have any oral surgery or tooth extractions planned or scheduled?	❒	❒
Do you have any ongoing problems with your teeth or jaw?	❒	❒
Are you allergic to any medicines? (list below)	❒	❒

If you answered yes to any of these questions, please give details below:

Please provide details requested below if you have ever taken any of the listed medications.

Medication	Dose (# pills or mg.)	Date Started	Date Stopped	Reason Stopped
Calcium				
Calcium with Vitamin D				
Multivitamin				
Vitamin D				
Estrogen Pill or Patch				
Testosterone				
Fosamax (alendronate)				
Actonel, Atelvia (risedronate)				
Evista (raloxifene)				
Miacalcin, Fortical (calcitonin)				
Forteo (teriparatide)				
Boniva (ibandronate)				
Reclast, Zometa (zoledronic acid)				
Prolia (denosumab)				
Aredia (pamidronate)				
Didronel (etidronate)				
Prednisone				
Depo-Provera				
Dilantin (phenytoin)				
Phenobarbital				
Tegretol (carbamazepine)				
Depakene (valproic acid)				
Tamoxifen				
Arimidex (anastrozole)				
Fareston (toremifene)				
Aromasin (exemestane)				
Faslodex (fulvestrant)				
Femara (letrozole)				
Lupron (leuprolide)				
Casodex (bicalutamide)				
Nilandrone (nilutamide)				
Zoladex (goserelin)				
Eulexin (flutamide)				
Heparin				
Lovenox (enoxaparin)				

Please list any other medicines and dose you are now taking. _____

_____

_____

_____

Operations (Type of surgery and date).

_____

_____

_____

_____

For women only:

At what age was your first period? _____ At what age was your last period? _____

Have you ever missed periods, besides during pregnancy? _____

Have you had cancer of the breast, ovary, uterus, or cervix? _____

Are you taking medicine for breast cancer? _____

Have you had a hysterectomy, and if so, were ovaries removed? _____

For men only:

Do you have erectile dysfunction (impotence)? _____

Do you have low testosterone? _____

Have you had cancer of the prostate? _____

Are you taking medicine for prostate cancer? _____

Please make additional comments here. _____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY FORM

PLEASE CHECK TO INDICATE ANY RECENT SYMPTOMS

GENERAL
- ❒ AIDS
- ❒ AIDS RISK FACTORS
- ❒ DEPRESSED
- ❒ FEVER
- ❒ LOSS OF APPETITE
- ❒ NERVOUS
- ❒ TIRED
- ❒ TROUBLE SLEEPING
- ❒ WEIGHT GAIN
- ❒ WEIGHT LOSS

EYES
- ❒ RED EYE
- ❒ VISUAL PROBLEMS

ENT
- ❒ DIZZINESS
- ❒ HAY FEVER
- ❒ HEADACHES
- ❒ HEARING PROBLEMS
- ❒ DENTAL PROBLEMS

ENDOCRINE
- ❒ DIABETES
- ❒ THYROID DISEASE

RESPIRATORY
- ❒ ASTHMA
- ❒ COUGHING
- ❒ COUGHING BLOOD
- ❒ SHORT OF BREATH

CARDIOVASCULAR
- ❒ CHEST DISCOMFORT
- ❒ CHEST PAIN
- ❒ HEART ATTACK
- ❒ HEART MURMUR
- ❒ HEART SKIPPING
- ❒ HIGH BLOOD PRESSURE
- ❒ HIGH CHOLESTEROL

GASTROINTESTINAL
- ❒ ABDOMINAL PAIN
- ❒ BLACK STOOL
- ❒ BLOOD IN STOOL
- ❒ CHANGE IN STOOLS
- ❒ CONSTIPATION
- ❒ DIARRHEA
- ❒ GALL STONES
- ❒ HEARTBURN
- ❒ HEMORRHOIDS
- ❒ HEPATITIS
- ❒ INDIGESTION
- ❒ JAUNDICE
- ❒ NAUSEA
- ❒ TROUBLE SWALLOWING
- ❒ ULCER
- ❒ VOMITING
- ❒ VOMITING BLOOD

UROLOGICAL
- ❒ BLADDER INFECTIONS
- ❒ BLOOD IN URINE
- ❒ BURNING ON URINATION
- ❒ FREQUENT URINATION
- ❒ KIDNEY INFECTIONS
- ❒ KIDNEY STONE

NEUROLOGICAL
- ❒ CONFUSION
- ❒ FAINTING
- ❒ NUMBNESS
- ❒ PARALYSIS
- ❒ POOR MEMORY
- ❒ SEIZURES
- ❒ STROKE
- ❒ TINGLING
- ❒ WEAKNESS

SKIN
- ❒ RASH
- ❒ ITCHING

HEMATOLOGICAL
- ❒ ANEMIA
- ❒ BLEEDING PROBLEM
- ❒ BLOOD CLOTS

MUSCULO-SKELETAL
- ❒ ARTHRITIS
- ❒ BACK PAIN
- ❒ GOUT
- ❒ SWOLLEN JOINTS

OSTEOPOROSIS
- ❒ LOW BONE DENSITY
- ❒ OSTEOPOROSIS
- ❒ BROKEN BONE

MALE ONLY
- ❒ IMPOTENCE
- ❒ PAINFUL TESTICLE
- ❒ PENILE DISCHARGE
- ❒ PROSTATE PROBLEMS
- ❒ SWOLLEN TESTICLE
- ❒ WEAK STREAM

FEMALE ONLY
- ❒ BREAST LUMP
- ❒ HOT FLASHES
- ❒ SWEATS
- ❒ PELVIC PAIN
- ❒ VAGINAL DISCHARGE

ANY OTHER PROBLEMS?

_____

_____

_____

Reviewed by: