



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

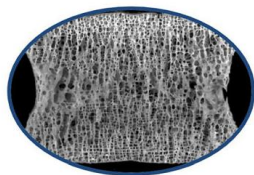
Date



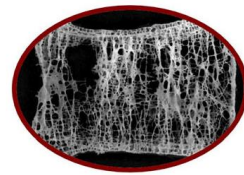
Now Available: Advanced Testing of Bone Strength with TBS

TBS means **T**rabecular **B**one **S**core. This is a newly developed test of your bone structure that is complementary to standard bone density testing. When TBS is combined with bone density testing, we learn more about your bone health than with bone density testing alone. TBS is important because about one-half of people who break bones do not have bone density that is classified as osteoporosis. TBS can help recognize these people and allow for more personalized care to prevent broken bones.

Below is an example of how TBS can help. These are two different patients with similar bone density. The one on the right has very poor bone structure compared with the one on the left and has a much higher risk of breaking bones. TBS can detect this degradation of bone structure. It can help us decide whether treatment is needed and what kind of treatment is best.



Good Bone Structure



Poor Bone Structure

TBS does not require any additional scanning. It uses advanced software cleared by the FDA to measure your bone structure with the same scan that measures your bone density. It is not covered by insurance at this time. The cost to you for TBS is \$50 (far less than the cost of having a broken bone). Let us know if you would like to have TBS included with your bone density test.

New Mexico Clinical Research & Osteoporosis Center, Inc.

Bone Densitometry: Patient History Form

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

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? Yes ___ No ___ If yes, when and where? _____

Ethnic Group:

Caucasian Hispanic Asian/Pacific Islander African American Native American Other _____

Gender: _____

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

Would you like to include your Trabecular Bone Score (TBS) in your report? (\$50 charge) Yes No

Osteoporosis Risk Factor Assessment

Have you: YES NO

Lost more than 1.5 inches in height? YES NO

Broken bones since age 40? YES NO

Ever taken steroids, such as prednisone, for more than 3 months? YES NO

Been on chemotherapy? YES NO

Had stomach surgery such as gastrectomy or stapling (surgery for obesity)? YES NO

Had anorexia? YES NO

Had bulimia? YES NO

Had an organ transplant? YES NO

Do you: YES NO

Smoke cigarettes? YES NO

Now take prednisone? YES NO

Have diabetes? YES NO

Have kidney disease? YES NO

Nephrologist: _____

Have rheumatoid arthritis? YES NO

Rheumatologist: _____

Take anticonvulsant medication, like Dilantin, YES NO

Phenobarb, or Tegretol?

Have any thyroid problems? YES NO

Hyper (overactive) _____ Hypo (underactive) _____

Endocrinologist: _____

Have any parathyroid problems? YES NO

Hyper (overactive) _____ Hypo (underactive) _____

Endocrinologist: _____

Have a high calcium level in your blood? YES NO

Have inflammatory bowel disease like Crohn's YES NO

Disease, or ulcerative colitis?

Have malabsorption problems or celiac disease? YES NO

Have a paralyzed arm or leg? YES NO

Have on average 3 or more alcohol drinks per day? YES NO

Does your mother or father have osteoporosis? YES NO

Mother _____ Father _____

Has your mother or father had a broken hip? YES NO

Mother _____ Father _____

At what age? _____

Gender Specific Risk Factors

For women only: YES NO

Are you currently having irregular periods? YES NO

Has there been an episode when your period stopped for a significant amount of time? YES NO

Have you ever had phlebitis or blood clots? YES NO

Have you had breast cancer? YES NO

If yes, date diagnosed _____

Right _____ Left _____

Chemo _____ Radiation _____ Surgery _____

Have you ever taken Femara (letrozole), Arimidex (anastrozole), Aromasin (exemestane), or Tamoxifen?

If yes, for how long? _____

Are you still taking it? YES NO

Have you had cancer of the...?

Ovary (right__ or left__) Uterus Cervix

None *Date diagnosed? _____*

Chemo _____ Radiation _____ Surgery _____

At what age was your LAST period? _____

At what age did menopause begin? _____

How did menopause begin?

Natural Chemotherapy Surgery

If by surgery, both ovaries or just one? Both One

New Mexico Clinical Research & Osteoporosis Center, Inc.

Bone Densitometry: Patient History Form

Name:	DOB:	Date:
-------	------	-------

For men only:	Unknown	YES	NO
Do you have erectile dysfunction		<input type="checkbox"/>	<input type="checkbox"/>
Do you have low testosterone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had prostate cancer?		<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, date diagnosed? _____</i>			
Hormone Therapy _____ Radiation _____ Surgery _____			
Are you currently receiving hormone therapy for prostate cancer?		<input type="checkbox"/>	<input type="checkbox"/>

General Health Information:

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

What was your **weight** at age 25? _____

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

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

	Are you on this now?	Dose	Date Started	Date Stopped	Reason Stopped
<input type="checkbox"/>	Calcium				
<input type="checkbox"/>	Calcium with Vitamin D				
<input type="checkbox"/>	Multivitamin				
<input type="checkbox"/>	Vitamin D				
<input type="checkbox"/>	Estrogen <input type="checkbox"/> patch <input type="checkbox"/> pill <input type="checkbox"/> cream				
<input type="checkbox"/>	Testosterone				
<input type="checkbox"/>	Prednisone				
<input type="checkbox"/>	Fosamax (alendronate)				
<input type="checkbox"/>	Actonel, Atelvia (risedronate)				
<input type="checkbox"/>	Evista (raloxifene)				
<input type="checkbox"/>	Miacalcin, Fortical (calcitonin)				
<input type="checkbox"/>	Forteo (teriparatide)				
<input type="checkbox"/>	Boniva (ibandronate)				
<input type="checkbox"/>	Reclast (zoledronic acid)				
<input type="checkbox"/>	Prolia (denosumab)				
<input type="checkbox"/>	Tymlos (abaloparatide)				
<input type="checkbox"/>	Didronel (etidronate)				
<input type="checkbox"/>	Evenity (romosozumab)				
<input type="checkbox"/>	Strontium				

New Mexico Clinical Research & Osteoporosis Center, Inc.

Bone Densitometry: Patient History Form

Name:	DOB:	Date:
--------------	-------------	--------------

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

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

For Official Use	
HT	cc:
WT	L R JC MG SE DXA

Notes
