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, No Show and cancellation/reschedules, 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 to avoid a No Show or cancellation/reschedule fee, 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

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:
☐ Bone Density Test (DXA) ☐ Vertebral Fracture Assessment (VFA)	☐ Service never paid due to medically unnecessary. ☐ Your diagnosis does not support the need for this service. ☐ Frequency Limitations for coverage	☐ **$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.

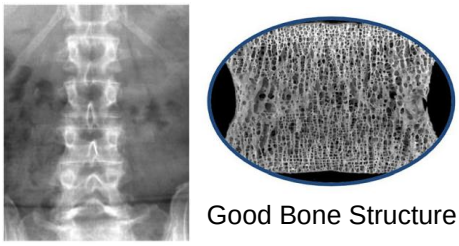
_____ _____

Signature **Date**

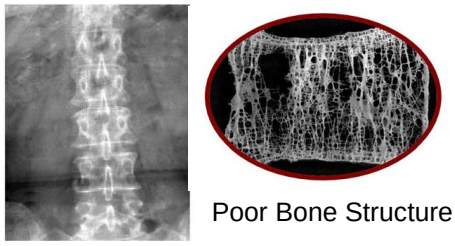
Now Available: Advanced Testing of Bone Strength with TBS

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?	☐	☐
Broken bones since age 40?	☐	☐
Ever taken steroids, such as prednisone, for more than 3 months?	☐	☐
Been on chemotherapy?	☐	☐
Had stomach surgery such as gastrectomy or stapling (surgery for obesity)?	☐	☐
Had anorexia?	☐	☐
Had bulimia?	☐	☐
Had an organ transplant?	☐	☐

Do you:	**YES**	**NO**
Smoke cigarettes?	☐	☐
Now take prednisone?	☐	☐
Have diabetes?	☐	☐
Have kidney disease?	☐	☐
Nephrologist: _____		
Have rheumatoid arthritis?	☐	☐
Rheumatologist: _____		
Take anticonvulsant medication, like Dilantin, Phenobarb, or Tegretol?	☐	☐
Have any thyroid problems?	☐	☐
Hyper (overactive) ____ *Hypo (underactive)* ____		
Endocrinologist: _____		
Have any parathyroid problems?	☐	☐
Hyper (overactive) ____ *Hypo (underactive)* ____		
Endocrinologist: _____		
Have a high calcium level in your blood?	☐	☐
Have inflammatory bowel disease like Crohn's Disease, or ulcerative colitis?	☐	☐
Have malabsorption problems or celiac disease?	☐	☐
Have a paralyzed arm or leg?	☐	☐
Have on average 3 or more alcohol drinks per day?	☐	☐
Does your mother or father have osteoporosis?	☐	☐
Mother _____ *Father* ____		
Has your mother or father had a broken hip?	☐	☐
Mother _____ *Father* _____		
At what age? _____		

Gender Specific Risk Factors

For women only:	**YES**	**NO**
Are you currently having irregular periods?	☐	☐
Has there been an episode when your period stopped for a significant amount of time?	☐	☐
Have you ever had phlebitis or blood clots?	☐	☐
Have you had breast cancer?	☐	☐
If yes, date diagnosed _____		
Right ___ *Left* ___		
Chemo ____ *Radiation*____ *Surgery* ___		
Have you ever taken Femara (letrozole), Arimidex (anastrazole), Aromasin (exemestane), or Tamoxifen?		
If yes, for how long? _____		
Are you still taking it?	☐	☐

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		☐	☐
Do you have low testosterone?	☐	☐	☐
Have you had prostate cancer?		☐	☐
If yes, date diagnosed? _____			
Hormone Therapy ____ *Radiation* ____ *Surgery* _____			
Are you currently receiving hormone therapy for prostate cancer?		☐	☐

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?
☐right ☐left		
☐right ☐left		
☐right ☐left		
☐right ☐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
❒	Calcium					
❒	Calcium with Vitamin D					
❒	Multivitamin					
❒	Vitamin D					
❒	Estrogen ❒patch ❒pill ❒cream					
❒	Testosterone					
❒	Prednisone					
❒	Fosamax (alendronate)					
❒	Actonel, Atelvia (risedronate)					
❒	Evista (raloxifene)					
❒	Miacalcin, Fortical (calcitonin)					
❒	Forteo (teriparatide)					
❒	Boniva (ibandronate)					
❒	Reclast (zoledronic acid)					
❒	Prolia (denosumab)					
❒	Tymlos (abaloparatide)					
❒	Didronel (etidronate)					
❒	Evenity (romosozumab)					
❒	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