

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)



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.

X

X

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.

- DXA
- 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



Osteoporosis Consultation: Patient History Form

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER

Form revised 05/20

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? _____

Should we send a copy of the consultation report to anyone else? _____

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

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Have you lost more than 2 in. height?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have inflammatory bowel disease, such as Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever broken a bone? (list your age, date, and circumstances for every fracture below)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have intestinal malabsorption, such as celiac disease?	<input type="checkbox"/>	<input type="checkbox"/>
Does your mother, father, brother, or sister have osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a gastrectomy (part of your stomach removed)?	<input type="checkbox"/>	<input type="checkbox"/>
Has your mother or father broken a hip?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have more than two drinks of an alcoholic beverage per day?	<input type="checkbox"/>	<input type="checkbox"/>	Have you fallen in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you weigh less than 127 lbs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a walking or balance problem?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have to push off on the arms of a chair to stand up?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any problems with infections or pain in your teeth or jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had vitamin D deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any oral surgery or tooth extractions planned or scheduled?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have lactose intolerance?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any ongoing problems with your teeth or jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Any difficulty with digestion?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any medicines? (list below)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hyperthyroidism (an overactive thyroid gland)?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had hyperparathyroidism, or a high calcium level in your blood?	<input type="checkbox"/>	<input type="checkbox"/>			

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)				
Tymlos (abaloparatide)				
Evenity (romosozumab)				
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
- NARROW ESOPHAGUS

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: