OSTEOPOROSIS SCREENING QUESTIONNAIRE
Rheumatology Associates of Delmarva

Name:______________________________ Date:______________________
Referring Physician:______________________ PCP:______________________
Additional Copies To:____
Sex:__________ Date of Birth: ______________ Age:______________
Weight: ________(pounds) Height ________(feet) ________(inches) Height Loss: ________ (inches)
Why are you having this bone density scan?_________________________________
____
Have you ever had a bone density test? YES/NO (circle one) Where?______________

GENETIC FACTORS: **Circle one**

Is there a family history of osteoporosis?________________________ YES NO
Has your mother, father, grandmother, aunt(s) and/or sisters(s) broken any bones including the hip, wrist or rib?________________________ YES NO
Have they had an exaggerated curvature of the spine (hump-back)?__________ YES NO

FOR WOMEN:

Is there a chance that you are pregnant?________________________ YES NO
Have your periods stopped?________________________ YES NO
If so, when was your last period (year)?________________________
Has your uterus been removed?________________________ YES NO
Have both ovaries been removed?________________________ YES NO
Have you had breast cancer?________________________ YES NO
Have you had ovarian cancer?________________________ YES NO
Have you had uterine cancer?________________________ YES NO

FOR MEN:

Have you ever been treated for prostate cancer?________________________ YES NO
Have you ever been treated for testicular hypofunction?__________________ YES NO
Do you take Lupron injections?________________________ YES NO

FACTORS THAT CAN PROTECT AGAINST OSTEOPOROSIS:

How many servings of dairy products do you have daily (milk, cheese, yogurt, etc.)?________ 0,1,2,3,4,5+
Do you have lactose or milk intolerance?________________________ YES NO
Do you exercise regularly?________________________ YES NO
If so, what type?________________________
Do you have any allergies to medication?________________________ YES NO
If so, which medication(s)?________________________ YES NO

MEDICATIONS:	Taking now?	Ever taken in the past, but not currently?	How much?	For how long?	If you stopped medication, when and why?
Calcium supplements (Includes TUMS)	YES NO	YES NO			
Multiple vitamins	YES NO	YES NO			
Vitamin D	YES NO	YES NO			
Estrogen	YES NO	YES NO			
Evenity/romosozumab	YES NO	YES NO			
Fosamax/alendronate	YES NO	YES NO			
Actonel/risedronate	YES NO	YES NO			
Forteo/teriparatide injections	YES NO	YES NO			
Evista/raloxifene	YES NO	YES NO			
Boniva/ibandronate (oral or intravenous)	YES NO	YES NO			
Prolia/denosumab	YES NO	YES NO			
Tymlos/abaloparatide	YES NO	YES NO			
Reclast/zoledronic acid	YES NO	YES NO			
Medications to prevent organ transplant rejection	YES NO	YES NO			

List All other prescriptions and over-the-counter medications currently taking:____________________

____

____

FACTORS THAT INCREASE THE RISK OF OSTEOPOROSIS: **Circle one**

Do you currently smoke? (Quantity) ____________________ YES NO

Former smoker? (Date Quit)____________________ YES NO

Do you drink alcohol?____________________ YES NO

If so, how much____________________

Have you taken steroid medications, such as Prednisone, dexamethasone or cortisone, longer than 3 months?____________________ YES NO

Do you take medications for seizures?____________________ YES NO

If so, which medication(s)?____________________

Have you been diagnosed with:

Kidney disease?____________________ YES NO

Liver disease?____________________ YES NO

Thyroid disease?____________________ YES NO

Rheumatoid arthritis?____________________ YES NO

Parathyroid disease?____________________ YES NO

Paget's disease of bone?____________________ YES NO

Digestive problems (ex. Celiac disease, Crohn's, UC, IBS, ulcers, GERD)?____________________ YES NO

FACTORS THAT INCREASE THE RISK OF OSTEOPOROSIS:

Circle one

Have you had cancer?____ YES NO

Did you have radiation or chemotherapy?______________________________ YES NO

Describe____

Have you ever had an eating disorder, such as anorexia or bulimia?________________ YES NO

Have you had a recent weight change?______________________________ YES NO

If yes, tell us about it.____

Have you ever broken/fractured any bones?____________________________ YES NO

Have you ever had surgery on either your hips or your spine?__________________ YES NO

How many times have you fallen in the last year?__________________________

Any other major health problems?______________________________________

____

Technician Comments:

Rheumatology Associates of Delmarva

Edmund J. MacLaughlin, MD, FACR, CCD
Elizabeth S. Clayton, MD, FACR
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Phone 410-819-6545
Fax 410-819-6750

10 Aurora Street
Cambridge, MD 21613
410-228-0556
410-228-3986

1415 S. Division Street
Salisbury, MD 21804
410-860-6801
410-860-6864

Financial Policy

We believe that everyone benefits when there is a definite and clear financial agreement prior to treatment. Our policy is as follows:

If applicable, your insurance co-pay is due upon service. Co-pays will be collected at the time of check-in.

Please understand that a referral from your family doctor may be necessary in order to submit claims to your insurance carrier. It is the **patient's responsibility** to obtain this referral. If a valid referral is not on file, then your appointment will have to be rescheduled.

There are a certain number of appointments available each day and often patients who are sick cannot be seen the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we require 24 hours' notice, so that we may schedule another patient into your appointment slot. If the required notice is not given, then a cancellation charge of $50.00 for new patients and $25.00 for established patients will be assessed to the patient, not billed to any insurance company. Until this fee is paid, another appointment will not be scheduled.

All accounts with a balance over 30 days will be assessed a 1.5% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing Manager (410-819-6630). If an account becomes assigned to a collection agency, the patient will pay 25% of the collection agency fees, 100% of court costs and 100% of attorney fees.

I hereby certify that I have read and understand the above and agree with all terms and conditions. I also authorize the release of any personal health information to my insurance company and another other health care professionals involved in my care.

Signed____ Date__________________

Printed Name____

Witness____

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PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Patient Name:____________________________________Date of Birth:__________________

Medicare#:________________________________Referring Provider:_____________________

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(s) (1) of the Medicare law. Your provider is in the best position to know the clinical assessment needs of his or her patients. In some cases, when your provider orders a specific test to detect pre-symptomatic diseases or, as part of a process to help determine what the diagnosis is, some insurers, including Medicare, will not pay for the test performed. In your case, you have been notified that Medicare may deny payment for the services indicated because Medicare usually does not pay for: a) This test for the reported condition; b) For non-FDA approved tests or c) For tests ordered for screening purposes.

By signing below, IF Medicare denies payment, <u>you agree to be FULLY responsible for payment.</u>

TO BE SIGNED BY THE PATIENT:

"I HAVE BEEN NOTIFIED THAT, IN MY CASE, Medicare may deny payment for the services. If Medicare denies payment, I agree to be responsible for payment. I understand that if the claim is denied, I will receive a bill from Rheumatology Associates of Delmarva for the denied services."

Signed: ____Date:_______________

Witness: ____

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Patient Authorization to Receive/Release Health Information

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Patient Name: ____

Date of Birth: ____________________ Social Security #: ____________________

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific description of the information to be used/disclosed:

Any records pertaining to the diagnosis and treatment of the rheumatologic conditions for which I am being seen.

Persons authorized to use or disclose the above "authorized information":

Rheumatology Associates of Delmarva employees

Person's to whom the use or disclosure of the authorized information may be made: Affiliated hospitals providing care for the above named patient, other physicians providing care for the patient, the patient's pharmacy, insurance companies, and in some cases, we may need to provide information to our accountant and/or lawyer.

We may leave messages/ detailed medical information on voicemail at either of these phone numbers?

Home Phone: ______________ Yes ___ No ___ Cell Phone: ______________ Yes: ___ No: ___

May we contact your place of employment? Yes ____ No ____

If so, may we leave a message? Yes ____ No ____

If yes: Work Phone: ____________________ Ext.: ______________

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, billing)?

Yes _____ No _____ **If yes, please provide:**

Name: ____________________ Relationship: ____________________

Phone Number: ____________________ Alternate Number: ____________________

Is this person your Power of Attorney for medical purposes? Yes _____ No _____

Name: ____________________ Relationship: ____________________

Phone Number: ____________________ Alternate Number: ____________________

Is this person your Power of Attorney for medical purposes? Yes _____ No _____

TURN OVER—COMPLETE BACK SIDE

Patient's Name: ______________________________

- ***I understand that if the person or entity receiving the authorized information listed above is not a health plan or health care provider covered by the federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.***
- ***I understand that I may revoke this authorization at any time by notifying Rheumatology Associates of Delmarva in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Rheumatology Associates of Delmarva prior to receiving my revocation.***

I hereby authorize Rheumatology Associates of Delmarva to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above.

I have reviewed the Rheumatology Associates of Delmarva Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Signed by: ______________________________ ______________________________
Signature of Patient or Personal Representative — Relationship to Patient

______________________________ ______________________________
Printed Name of Personal Representative — Date

Witnessed by: ______________________________ ______________________________
Signature — Date

____
Printed Name

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION