CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

SCAN+ NOT SUPPORTED

DEXA SCREENING FORM

Name: DOB: Age: Weight: Height: Sex:
Ethnicity: Menopause Age:

☐ Yes ☐No Have you had a previous hip or vertebral fracture?
☐ Yes ☐No Have you had any fractures 40+ years old from significant trauma? (i.e. car accident)
☐ Yes ☐No Did either of your parents ever have a hip fracture?
☐ Yes ☐No Do you smoke?
☐ Yes ☐No Have you ever taken Glucocorticoids?
☐ Yes ☐No Do you have rheumatoid arthritis?
☐ Yes ☐No Do you have secondary osteoporosis?
☐ Yes ☐No Do you drink 3 or more alcoholic drinks per day?
☐ Yes ☐No Are you being treated for osteoporosis?

Have you ever taken any of the following medications?

☐Actonel (i.e. risedronate)
☐Boniva (i.e. ibandronate)
☐Evista (i.e. raloxifene)
☐Forteo (i.e. parathyroid hormone)
☐Fosamax (i.e. alendronate)
☐HRT (i.e. estrogen/hormone therapy)
☐Miacalcin (i.e. calcitonin)
☐Protelos (i.e. strontium ranelate)
☐Reclast (i.e. zoledronate)
☐Prolia (i.e. denosumab)
☐Vitamin D
☐Calcium
☐Other- Please specify _____

Do you have any of the following medical conditions?

☐Anorexia or Bulimia
☐Any Seizure Disorder
☐Asthma or Emphysema
☐Cancer
☐End stage renal disease
☐Inflammatory bowel disease
☐Hyperparathyroidism
☐Hysterectomy
☐Other- Please specify _____

What is you maximum height (inches)? _____

☐ Yes ☐No Do you perform weight bearing exercise regularly?
☐ Yes ☐No Do you regularly consume dairy products?
☐ Yes ☐No Do you drink caffeinated beverages?

If female:

At what age did your period start? _____

☐ Yes ☐No Are you premenopausal?

How many full-term pregnancies have you had? _____

☐ Yes ☐No Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)?

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PATIENT INFORMATION & BILLING AUTHORIZATION

PATIENT: _____

Last Name First Name Middle Name

_____

Sex Date of Birth

ADDRESS: _____

Street City State Zip Code

PHONE: _____

Home Phone Cell Phone ****E-MAIL FOR PATIENT PORTAL****

INSURANCE: _____

Company Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Secondary: _____

Secondary Policy Number Group Number

_____

Name of Policy Holder Date of Birth Policy Holder Sex

Referring provider(s): _____

List primary care physician or any other doctors to receive your reports: _____

(First and last name)

(____) **MEDICARE (initial if you are covered by Medicare)** I request that payment of authorized Medicare benefit be made to CHARTER RADIOLOGY LLC for any services they furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowed amount. The patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and the deductible are based on the charge determination of Medicare Carrier.

(____) **MEDICAL INSURANCE (initial if you are covered by any medical insurance. This also includes Medigap, Worker's Compensation or Personal Injury Protection benefits/Auto)** I authorize payment of medical benefits, otherwise payable to me, to CHARTER RADIOLOGY, LLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize Charter Radiology LLC to release to my insurance company any medical information for processing of a claim. I authorize Charter Radiology LLC to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

_____

Date **Signature** of patient or parent (if under age 18)

_____

Print full name of responsible party if patient is a minor

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I acknowledge that I can request a copy of Charter Radiology's Notice of Privacy Practices which provides information about ways my protected health information ("PHI") may be used and disclosed by Charter Radiology and states my rights with respect to my PHI. I understand that Charter Radiology has the right to revise these practices and if the terms of the Notice of Privacy Practices change, a revised Notice will be made available to me. Please note: In accordance with Maryland Law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records, must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.

In addition, by signing this form, I hereby voluntarily authorize the use and/or disclosure of all or any part of my PHI as described in this Authorization by Charter Radiology and its employees, agents, and third parties acting on its behalf as follows: (1) anonymous images of me may be used by Charter Radiology for teaching or educational purposes and (2) in order to facilitate the healthcare services provided to me, Charter Radiology may engage in the following:

- Call, email or send a text to me to confirm appointments Yes____ No____
- Leave a message on my home answering machine and/or cell phone Yes____ No____
- Discuss my medical condition with the following individuals: (i.e. relative or friend)

Name of Individual	**Phone Number**	**Email Address**
_____	_____	_____

My signature below means that I understand and agree to the following:

- My PHI may be protected by law. My PHI that is disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Charter Radiology will not condition my treatment on whether I sign this Authorization.
- Without my signature below, this Authorization will not be honored.
- I may receive a copy of this form if I ask for it in writing addressed to Charter Radiology.
- This authorization will expire six (6) years from the date set forth below, unless I revoke it sooner. If I sign this form, I may revoke this Authorization at any time by notifying Charter Radiology in writing at the address below. Revoking this Authorization will not have any effect on actions that Charter Radiology took in reliance on the Authorization before it received notice of my revocation.

_____ _____

Signature of Individual or Representative Date

_____ _____

Printed Name of Individual Relationship to Individual (if signed by Personal Representative)