OSTEOPOROSIS ASSESSMENT CENTER

A Division of Arthritis & Rheumatism Associates, P.C.
2730 UNIVERSITY BOULEVARD WEST, SUITE 710, WHEATON, MD 20902 301-949-1134
14955 SHADY GROVE ROAD, SUITE 230, ROCKVILLE, MD 20850 301-251-5910
2021 K STREET, N.W., SUITE 300, WASHINGTON, DC 20006 202-293-1470

PATIENT NAME LAST FIRST MIDDLE | HOME PHONE | CELL PHONE

HOME ADDRESS | APT NO. | CITY | STATE | ZIP

PATIENT STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER : | ☐ EMPLOYED ☐ FT STUDENT ☐ PT STUDENT

EMPLOYER | ADDRESS | WORK PHONE

PATIENT'S OCCUPATION (INDICATE IF STUDENT) | SOCIAL SECURITY NO. | DATE OF BIRTH | SEX ☐ M ☐ F

FINANCIALLY RESPONSIBLE PARTY ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER: | RESPONSIBLE PARTY'S NAME | WORK PHONE

RESPONSIBLE PARTY'S ADDRESS | HOME PHONE

REFERRED BY | ADDRESS | PHONE

REFERRED BY | ADDRESS | PHONE

IN CASE OF EMERGENCY, PLEASE NOTIFY:
Name____
First Middle Last
Address____

Relationship____________________
Home Phone ( )________________
Work Phone ( )________________

INSURANCE INFORMATION

Do you have health insurance? ☐ yes ☐ no (If yes, please complete the following information)

PRIMARY INSURANCE COMPANY | POLICY/ID NO. | GRP. NO/SERV. CODE

PRIMARY INSURANCE COMPANY ADDRESS
____Phone ( )________________
Street Suite # City State Zip

Name of Policyholder______________________________ ☐ Male ☐ Female Relationship____________________

POLICYHOLDER'S DATE OF BIRTH | POLICYHOLDER'S ADDRESS

POLICYHOLDER'S EMPLOYER OR SCHOOL NAME | POLICYHOLDER'S WORK PHONE

SECONDARY INSURANCE COMPANY | POLICY/ID NO. | GRP. NO/SERV. CODE

SECONDARY INSURANCE COMPANY ADDRESS
____Phone ( )________________
Street Suite # City State Zip

Name of Policyholder______________________________ ☐ Male ☐ Female Relationship____________________

POLICYHOLDER'S DATE OF BIRTH | POLICYHOLDER'S ADDRESS

POLICYHOLDER'S EMPLOYER OR SCHOOL NAME | POLICYHOLDER'S WORK PHONE

IS THIS CONDITION RELATED TO: ☐ EMPLOYMENT ☐ AUTO ☐ OTHER ACCIDENT | IF AUTO, IN WHICH STATE DID ACCIDENT OCCUR?

DATE OF ACCIDENT | CLAIM/FILE NO. | INSURANCE CARRIER

INSURANCE CARRIER ADDRESS | EMPLOYER NOTIFIED? ☐ YES ☐ NO | UNABLE TO WORK FROM: TO:

PLEASE TURN OVER FOR ADDITIONAL INFORMATION

PLEASE READ AND SIGN

Medicare Patients Only

"I request that payment of authorized Medicare benefits be made on my behalf to The Osteoporosis Assessment Center for any services furnished to me by that physician or supplier. 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 for related services."

Signature of policyholder or beneficiary ____ Date ______________________

Other Insurance

I hereby authorize The Osteoporosis Assessment Center to apply for benefits on my behalf for covered services rendered by Arthritis & Rheumatism Associates, P.C. and request that the payments from Blue Cross and Blue Shield of the National Capital Area and/or ______________________________________ be made directly to the above named provider.
(OTHER INS CO. NAME)

Signature of policyholder or beneficiary ____ Date _____________________

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

Signature of policyholder or beneficiary ____ Date _____________________

Medigap Patients Only

"I request that payment of authorized Medigap benefits be made on my behalf to The Osteoporosis Assessment Center for any services furnished to me by that provider of services or supplier. I authorize any holder of Medicare information about me be released to ____ any information deeded to determine these benefits payable for related services." (NAME OF MEDIGAP INSURER)

Signature of policyholder or beneficiary ____ Date _____________________

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BOARD CERTIFIED RHEUMATOLOGISTS

HERBERT S.B. BARAF, MD FACP FACR
ROBERT L. ROSENBERG, MD FACR †
EVAN L. SIEGEL, MD FACR
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SHARI B. DIAMOND, MD FACR
ASHLEY D. BEALL, MD FACR
ANGUS B. WORTHING, MD FACR
GUADA R. RESPICIO, MD

† - medical director

DEXA Medical History

Name: (Last, First, MI): ________________________ Date of Birth: ____________

Date of Service: ____________________ **(Office Use Only)** Medical Record #: ______________

Please Answer the Following Questions

Race: O Caucasian O Asian O Hispanic O Black O Other ____________________

Sex: O Female O Male **Ordering Physician:** ______________________________

Have you ever had a bone density test before? .... O Yes O No

If yes, when? ______________________ Where? ______________________

Have you fractured any bones after the age of 18? .... O Yes O No

If yes, what? ______________________ When? ______________________

Did your Mother or Father have a hip fracture (s)? .... O Yes O No

Do you currently smoke? .... O Yes O No

Do you consume one or more alcoholic beverages daily? .... O Yes O No

Women Only:

Are you Post Menopause?................ O Yes O No Age at Menopause? ______________

Are you currently on Hormone Replacement Therapy? (HRT/ERT)? .... O Yes O No

Have you ever taken Provera (Depo-Provera)?................ O Yes O No If Yes, How long? ______________

If you are Premenopausal, when was your last menstrual period? ______________________________

Are you currently on Birth Control Pills?................ O Yes O No Are you currently Pregnant?.... O Yes O No

Men Only:

Hypogonadism (Low Testosterone) .... O Yes O No

Lupron Depot .... O Yes O No

Have you ever been diagnosed with any of the following conditions?

Hyperparathyroidism .... O Yes O No

Lupus .... O Yes O No

Paget's Disease .... O Yes O No

Kidney Disease .... O Yes O No

Crohn's/Colitis/Celiac Disease................ O Yes O No

Rheumatoid Arthritis .... O Yes O No

Ankylosing Spondylitis .... O Yes O No

Liver Disease (i.e.: Hepatitis) .... O Yes O No

Kidney Stones .... O Yes O No

Have you ever had any of the following procedures?

Gastric Bypass/Lap Band? .... O Yes O No

Orthopedic hardware/medical devices in your hips and/or spine? .... O Yes O No

Cancer(s) .... O Yes O No

If Yes, type(s)? ______________________ When? ______________________

Have you had Radiation Therapy? .... O Yes O No Have you had Chemotherapy? .... O Yes O No

If Yes to Breast Cancer, have you ever taken Aromatase Inhibitor Therapy Drugs [Arimidex, (Anastrozole), Femara, (Letrozole), Aromasin (Exemestane), etc.]? .... O Yes O No

Have you ever taken Tamoxifen? .... O Yes O No

A DIVISION OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

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CENTRAL CALL CENTER 301.942.7600 • www.washingtonarthritis.com

Are you taking/have you taken any of the following medications?

Steroids for 3 months or longer (Prednisone, Cortisone) ………………………………………………………………….. O Yes O No

If Yes, for what condition(s)? ____

Thyroid Medication ..………………………….	O Yes	O No	Anti-seizure/epilepsy Meds ………………….	O Yes	O No
Antidepressants (SSRI: Drugs like Prozac)…….	O Yes	O No	Insulin dependent Diabetes …………………..	O Yes	O No

Are you taking or have you ever taken any of the following medications?

Actonel (Risedronate)…………………………..	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Aredia (Pamidronate)…………………………..	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Boniva (Ibandronate)…………………………...	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Evista (Raloxifene)……………………………..	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Forteo (Teriparatide)…………………………...	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Fosamax (Alendronate)………………………...	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Miacalcin/Fortical (Calcitonin)………………...	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Prolia (Denosumab)…………………………….	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Reclast (Zoledronate)…………………………..	O Yes	O No	How Long? __________________	If Stopped, when? _____________
Zometa (Zoledronic Acid) ……………………..	O Yes	O No	How Long? __________________	If Stopped, when? _____________

Do you take any of the following supplements?

Calcium…………………………………………	O Yes	O No	If Yes, Dose: ____
Vitamin D ………….…………………………..	O Yes	O No	If Yes, Dose: ____
Mulivitamin ……….…………………………...	O Yes	O No	If Yes, Dose: ____

Please list any additional medications you are currently taking and the dosage (if appropriate):

MEDICATIONS	DOSE	MEDICATIONS	DOSE
_______________________________________	_________________	____________________________________	__________________
_______________________________________	_________________	____________________________________	__________________
_______________________________________	_________________	____________________________________	__________________
_______________________________________	_________________	____________________________________	__________________
_______________________________________	_________________	____________________________________	__________________

OFFICE USE ONLY

Tallest Height: ________________ Height (in):________________ Weight (lbs): _______________

Dietary Calcium:

____
____
____
____
____

Patient Exercise: O Yes O No

____
____
____
____
____

General Comments:

____
____
____

Counseling and educational material given to patient? ....O Yes O No

Diagnoses: ____

Signature of DEXA Technologist: ____ Date: ___________________________

Physician Signature: ____

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FINANCIAL POLICY STATEMENT

Welcome to the Osteoporosis Assessment Center (OAC). **We are pleased to have you as a patient and we are committed to providing you with the best medical care possible. In order to assist you in receiving the maximum benefits allowable by your insurance, we ask that you *read and sign* this statement. We must emphasize that as medical care providers, our relationship is with you and *not* your insurance carrier. As a courtesy to you, we may file your claim, however *you* are responsible for charges incurred from the date services are provided, unless our contractual agreement with your carrier states otherwise. Because of the ongoing growth and change in available health care plans, it is *imperative* that you understand your benefits and responsibilities *prior* to being seen at OAC.**

MEDICARE PART B

OAC participates with Medicare and accepts assignment. We will file your claim and *require* that you pay any *deductible and your 20% co-insurance at the time of checkout*. In order to receive a non-covered supply or service, you will be required to sign a Medicare waiver *and pay in full.* If you have a secondary insurance, we will file for you, and you will be billed for any remaining balance. ARA does not participate with any Medicare Advantage Plans. If you have a Medicare Advantage HMO plan, you will *not* have any out of network benefits. If you are covered by a Medicare Advantage PPO plan that allows you to go out of network, you may have deductible and co-insurance payments that are determined by each individual Medicare Advantage Plan.

CAREFIRST BLUE CROSS BLUE SHIELD

OAC is a participating provider with CareFirst of the National Capital area and CareFirst of Maryland. Our contract with CareFirst includes all products: HMO (Blue Choice), Point of Service, Federal Employee, PPO, Blue Card, National Account and Indemnity Plans.

PPO, POS and HMO Plans

Currently, OAC participates with Aetna PPO, OneNet (formerly Alliance), MAMSI Life and Health, MDIPA, Optimum Choice, First Health, United Health Care, and Priority Partners. All PPO and HMO patients are *required to pay their co-payment* at *check-in.* Those patients whose plan requires a referral to see a specialist must present it at *check-in* or sign a *waiver* agreeing to pay for all services rendered. Those using a POS benefit will be required to sign a referral waiver and to pay any deductible or co-insurance their plan requires. OAC will be in violation of our contracts if we fail to collect these contracted obligations.

LIABILITY CASES/AUTO ACCIDENTS

OAC will not bill PIP. Physicians will treat patients with liability/auto accident cases, but their health insurance carrier will be billed for all services rendered. In the event that a patient does not have health insurance (or their health insurance denies the claim), payment will become the responsibility of the patient.

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WORKER'S COMPENSATION

If an injury is work-related, the patient must provide this office with complete billing information prior to treatment. We will need: active claim number, carrier name, adjustor's name, phone number and pre-authorization. If the case is being contested by an employer, then it will not qualify as a workers compensation case until an independent medical examiner, or the court, rules. In this circumstance we will bill the health insurance carrier. If a patient does not have health insurance, payment will be required at the time of service.

ALL OTHER INSURANCE (INCLUDING SECONDARY/TERTIARY)

As a courtesy to you, OAC will file your *primary* insurance claim once, provided that we have complete insurance information at the time of service. We *do not* file secondary or tertiary insurance claims unless contractually obligated to do so. Depending on the carrier, you may be asked to pay your balance in full or any deductible or co-payment due. Any balances not paid within 45 days will be changed to patient responsibility.

SELF-PAY

Patients without health insurance will be expected to *pay in full for all services rendered at the time of service.* To reduce cost at time of service, some lab work may be billed to the patient by the lab at a later date, although this option will result in higher overall cost to the patient. Any special payment arrangements must be set up with the Business Office *prior* to the visit. We accept cash, checks, money orders, and MC or VISA.

NON SUFFICIENT FUNDS (NSF) POLICY

A $50.00 NSF fee will be added to any patient's account that is returned by our bank for non sufficient funds.

ARA CANCELLATION POLICY

We request that cancellations or scheduling changes be made at least 24 hours in advance of your appointment. We reserve an appointment time exclusively for you. Without proper notification we cannot utilize the time slot you vacate to care for someone else. OAC has a missed appointment fee of $50.00.

ASSISTANCE

Our Business Office staff is available to assist you with any special concerns or questions. Please feel free to call (301) 942-3126 or stop by our location in Room 708 of the Westfield North building for personal attention.

RESPONSIBILITY

"I understand that I am responsible for *any outstanding balance.* In the event my account is turned over (for collections) or (to a third party), I will be responsible for any and all collection costs, interest, Attorney's fees and Court costs. I have read, understand and agree to abide by the policies of OAC as stated in this document"

Signature__________________________________ (SEAL) Date:_____/_____/_____

Thank you for choosing the Osteoporosis Assessment Center,
a Division of Arthritis and Rheumatism Associates, P.C.,

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