

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
 5530 WISCONSIN AVENUE, SUITE 1150, CHEVY CHASE, MD 20815 240-497-0230
 2021 K STREET, N.W., SUITE 300, WASHINGTON, DC 20006 202-293-1470

PATIENT NAME LAST FIRST			HOME PHONE	CELL PHONE
HOME ADDRESS		APT NO.	CITY	STATE
PATIENT STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER :		<input type="checkbox"/> EMPLOYED <input type="checkbox"/> FT STUDENT <input type="checkbox"/> PT STUDENT		
EMPLOYER		ADDRESS		WORK PHONE
PATIENT'S OCCUPATION (INDICATE IF STUDENT)		SOCIAL SECURITY NO.	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
FINANCIALLY RESPONSIBLE PARTY <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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:			Relationship _____	
Name _____			Home Phone () _____	
Address _____			Work Phone () _____	
INSURANCE INFORMATION				
Do you have health insurance? <input type="checkbox"/> yes <input type="checkbox"/> no (If yes, please complete the following information)				
PRIMARY INSURANCE COMPANY		POLICY/ID NO.	GRP. NO/SERV. CODE	
PRIMARY INSURANCE COMPANY ADDRESS				
Street		Suite #	City	State Zip
Name of Policyholder _____ <input type="checkbox"/> Male <input type="checkbox"/> 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				
Street		Suite #	City	State Zip
Name of Policyholder _____ <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER ACCIDENT			IF AUTO, IN WHICH STATE DID ACCIDENT OCCUR?	
DATE OF ACCIDENT	CLAIM/FILE NO.	INSURANCE CARRIER		
INSURANCE CARRIER ADDRESS		EMPLOYER NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> 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 the Osteoporosis Assessment Center 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 Arthritis & Rheumatism Associates, P.C. 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 needed to determine these benefits payable for related services." (NAME OF MEDIGAP INSURER)

Signature of policyholder or beneficiary _____ Date _____

OSTEOPOROSIS ASSESSMENT CENTER

BOARD CERTIFIED RHEUMATOLOGISTS

NORMAN S. KOVAL, MD FACP FACR *
HERBERT S.B. BARAF, MD FACP FACR
ROBERT L. ROSENBERG, MD FACP †
EVAN L. SIEGEL, MD FACR

EMMA DiORIO, MD FACR †
DAVID G. BORENSTEIN, MD FACP FACR
JOHN L. LAWSON, MD FACR †
WERNER F. BARTH, MD MACP MACR

ALAN K. MATSUMOTO, MD FACR
JOSEPH D. CROFT JR. MD FACP MACR
ROBERT L. LLOYD, MD FACR
DAVID P. WOLFE, MD FACR
*- founder †-medical director

DXA MEDICAL HISTORY – INITIAL SCAN

NAME: _____ DATE: _____

TECH: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F

RACE (CIRCLE ONE): ASIAN BLACK HISPANIC WHITE OTHER

REFERRING DOCTOR NAME & ADDRESS: _____

Have you had a DXA scan previously? Y N

When? _____ Where? _____

From what region or country is your family ancestry? _____

Check anything below that applies to you:

___ Alcohol number of drinks per week _____

___ Bone Abnormality hip wrist spine

Any surgery on above Y N when: _____

___ Arthritis

___ Bone Loss/Osteoporosis

___ Broken Bones hip spine wrist ankle
when: _____

___ Cushing's Syndrome

___ Cancer date _____ type _____

Do you weigh less than 127 lbs? Y N

___ Family History of Osteoporosis

___ Elevated Blood Calcium

___ High Blood Pressure

___ High Cholesterol

___ Hysterectomy – Complete or Partial age _____

___ Lactose Intolerant

___ Liver Disease

___ Kidney Disease

___ Malabsorption Syndrome (Celiac Disease)

___ Menopause Age _____

___ Paget's Disease

___ Parathyroid (Hyperparathyroid) Disease

___ Prolonged Immobility (Longer than 6 weeks)

___ Radiation/Chemotherapy when _____

___ Seizure Disorder

___ Smoker Y N packs per day _____

___ Steroid use (Prednisone, Cortisone)

___ Thyroid Disease

___ Hyperthyroid (Overactive)

___ Hypothyroid

___ Vitamin D Deficiency

List all current medications:

NAME	DOSE	CONDITION TREATED

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

2730 University Boulevard West, Suite 310, Wheaton, Maryland 20902. 301.949.1134. FAX 301.942.3132

14955 Shady Grove Road, Suite 230, Rockville, Maryland 20850. 301.251.5910. FAX 301.251.5913

2021 K Street, N.W., Suite 300, Washington, DC 20006. 202.293.1470 FAX 202.293.9416

5530 Wisconsin Avenue, Suite 1150, Chevy Chase, Maryland 20815. 240.497.0230. FAX 240.497.0233

www.washingtonarthritis.com

DO NOT WRITE BELOW THIS LINE

PATIENT ASSESSMENT

LVA Guidelines (2 or more points justifies LVA)

Tallest Height _____ Current Weight _____

Current Height _____

Diet & Lifestyle

Exercise: Y N If yes, type _____

Days per week _____

Dietary Calcium Intake: Dairy Products
Calcium Fortified Products

Comments: _____

	Score
Patient receiving Forteo (teriperitide)	2
T-score < -2.5 on DXA	2
Age > 75 years	2
History of vertebral fracture	2
Age > 65 years	1
History of non-vertebral fracture	1
Height loss > 1.5 inches	1
Weight loss > 11 lbs.	1
Daily steroids	1

Calcium Intake Totals: Supplement _____ Vitamin _____

Menstrual History

Age menstruation began: _____ Current status: menstruating Y N

LMP Date: _____

Perimenopausal: _____ Post-Menopausal since: _____

Hormone Therapy: Y N Type: _____ How Long: _____

Bone Therapy Drug Use: Y N Rx _____ Length of Time _____

Technologist Comments: _____

Technologist Signature _____

Physician Initials _____

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ROBERT J. LLOYD, MD FACR
PAUL J. DEMARCO, MD FACP FACR
SHARI B. DIAMOND, MD

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. In view 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 ARA.

MEDICARE PART B

ARA 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

Effective May 1, 2007, ARA has become 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, ARA participates with Aetna PPO, OneNet (formerly Alliance), Great West, MAMSI Life and Health, MDIPA, Optimum Choice, NCPPO, 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. We will be in violation of our contracts if we fail to collect these contracted obligations.

THIRD PARTY INSURANCE (Workers Comp or Accident/Liability)

Patients with Workers Comp claims will *only* be seen *after* verification of their claim status. We do *not* accept accident or liability cases without assured payment at the time of service. This means payment by the patient directly or by a health insurance carrier with which we participate.

ALL OTHER INSURANCE (INCLUDING SECONDARY/TERTIARY)

As a courtesy to you, ARA 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.

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 Wheaton 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 ARA as stated in this document”

Signature _____ (SEAL) Date: __/__/__

Thank you for choosing Arthritis and Rheumatism Associates, P.C., a progressive health care team dedicated to excellence in patient care and service.