

ZILKHA RADIOLOGY

Long Island Magnetic Resonance Imaging, P.C.

Long Island Medical Imaging, P.C.

Long Island Medical Diagnostic Imaging, P.C.

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1161 MONTAUK HIGHWAY
WEST ISLIP, NY 11795
(631) 669-1717 /FAX (631) 669-2227

BONE DENSITY (DEXA)

Today's Date _____ Time of Appointment _____ Time of Arrival _____

Patient Name _____ Date of Birth _____ **Male** **Female**

Street _____ Town _____ State _____ Zip _____

Social Security # _____ Home Telephone # _____ Mobile # _____

Employer _____ Work Telephone # _____

Primary Insurance _____ Policy # _____ Group # _____

Policy Holder (If not yourself) _____ Relationship **Spouse** **Parent** **Dependent** **Other**

Policy Holder's: Date of Birth _____ Social Security # _____ Employer _____

Secondary Insurance _____ Policy # _____ Group # _____

Policy Holder _____ Date of Birth _____ Relationship **Spouse** **Parent** **Dependent** **Other**

Referring Doctor Name & Phone # _____

Other Doctor's you want your results sent to: _____
(Name, Town & Phone Number)

AUTHORIZATION FOR TREATMENT: I hereby consent to treatment by the radiologist and other medical staff for all tests and/or procedures by Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C.

Patient or Legal Guardian Initial _____

ASSIGNMENT OF BENEFITS: I hereby assign Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. to release any information acquired in the course of my examination and treatment to my insurance company.

Patient or Legal Guardian Initial _____

AUTHORIZATION OF PAYMENT: I hereby assign payment to Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. for the medical benefits due under the terms of my insurance policy. I fully understand that I am financially responsible for my deductible, co-payment, co-insurance, and charges not covered by my health insurance plan.

Patient or Legal Guardian Initial _____

NOTICE OF PRIVACY PRACTICES (HIPAA) & RELEASE OF MEDICAL RECORDS: I acknowledge that I have been provided with a copy of Long Island Magnetic Resonance Imaging, P.C., Long Island Medical Imaging, P.C., and/or Long Island Medical Diagnostic Imaging, P.C. (the Practice's) Notice of Privacy Practices. I authorize release of my films/images, reports and/or medical records to my referring doctor, and any other doctor listed above. I authorize the persons listed below to discuss or retrieve any information pertaining to my treatment. (Photo ID required)

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

I hereby authorize a photo copy of this form to be valid as the original. This authorization will remain in effect unless changed by myself. I have read and understand the above, and agree to the terms listed above.

Patient or Legal Guardian Signature _____ **Date** _____

FEMALES:

- Yes**, I am pregnant **No**, I am not pregnant
- Yes**, I am nursing **No**, I am not nursing

Signature _____ Date _____

LMP _____ At what age did you begin menopause (V49.81)? _____

Have you had surgery to your ovaries, uterus, or cervix (V45.77)? **YES NO**

- Hysterectomy** (removal of uterus and/or the cervix) **Oophorectomy** (removal of ovary(s))

Are you **currently** on hormone replacement therapy **HRT** or estrogen replacement therapy **ERT** (V58.69)?

YES NO List _____

Have you **completed** hormone replacement therapy **HRT** or estrogen replacement therapy **ERT** (V67.51)?

YES NO List _____

Are you experiencing other menopausal or postmenopausal symptoms, disorders or complications (627.9)?

YES NO List _____

ALL PATIENTS:

Height: _____ Weight: _____ Are you- **RIGHT HANDED** **LEFT HANDED**

Have you ever had a bone density test before? **YES NO** When? _____ Where? _____

Why are you having a bone density today? _____

Did you take calcium supplements today? **YES NO** (If yes, you have to reschedule your appointment)

Are you **currently** taking a FDA approved osteoporosis drug therapy (V58.69)? **YES NO**

Select: **FOSAMAX** **ACTONEL** **BONIVA** **EVISTA** **NOLVADEX** **OTHER**

Have you **completed** drug therapy for osteoporosis and are here to monitor your response to treatment (V67.51)?

YES NO List _____

Do you have hyperparathyroidism (252.01)? **YES NO**

Did you have an X-Ray recently which showed vertebral abnormalities (793.7)? **YES NO**

Are you currently taking glucocorticoid (steroid) therapy for a period longer than 3 months, such as prednisone (V58.65)?

YES NO List _____

Any other medical conditions we should be aware of? _____

◆◆Please be aware that most insurance companies do not feel a bone density (DEXA) is medically necessary until two years have passed since your last bone density, and you are least 55 years of age. Some insurance plans will cover this test once a year if [1] you are taking a steroid therapy for more than three months and/or [2] your doctor needs to monitor your progress on a FDA approved osteoporosis drug therapy. It is our policy to do all we can to try to receive payment from your insurance carrier. Due to the above, we require all patients (except Medicaid) to complete a waiver of liability (ABN). If we cannot receive payment from your insurance company, you will be responsible for the test. ◆◆

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature

Date