Name: ____________________________ Age: _____

Date of birth: ________ Height as a young adult: _____

CURRENT PROBLEM

Prior diagnosis of osteoporosis or osteopenia? yes / no

If yes, when? __________

Have you had a DEXA (bone density) scan? yes / no

If yes, when was your most recent DEXA scan? _______

What bones have you broken after age 49?

Bone	Date
____________________________	____________
____________________________	____________
____________________________	____________

Do you take calcium supplements? yes / no

Do you take vitamin D supplements? yes / no

Have you taken medication for osteoporosis? yes / no

If yes, what medication? (circle all that apply):

Forteo (teriparitide) / Tymlos (abaloparatide)

Prolia (denosumab) / Fosamax (alendronate)

Boniva (ibandronate) / Actonel (risedronate)

Reclast (zolendronate) / not sure / other

Do you take oral steroids regularly? yes / no

Have you fallen within the last year? yes / no

Did either of your parents have a hip fracture? yes / no

Do you exercise regularly? yes / no

For women: What was your age at menopause? ______

Have you taken hormone replacement therapy? yes /no

MEDICAL PROBLEMS

rheumatoid arthritis / kidney disease / diabetes / cancer

stroke / dental infections / GERD / stomach ulcers

thyroid disease / parathyroid disease / osteoporosis

Other: ______________________________________

____

PRIOR SURGERIES

Have you had a gastric bypass? yes / no

Other surgeries: _______________________________

____

MEDICATIONS

____

____

____

ALLERGIES

____

SOCIAL

Do you use a: cane / walker / wheelchair / other

Do you smoke? yes / quit smoking / never smoked

____ packs/day x ____ years. If quit, when? _______ ☺

Alcohol: _____ drinks per day/week

Drugs: marijuana / cocaine / opiates / other

REVIEW OF SYSTEMS *Are you experiencing:*

fever / chills / fatigue / weight loss / frequent falls

rashes / wounds / itching

vision changes / hearing changes

chest pain / palpitations / pain with breathing

cough / wheezing / shortness of breath

nausea / vomiting / diarrhea / constipation / heartburn

pain with urination / incontinence

leg swelling / calf pain / easy bruising

joint pain / muscle aching / back pain / stiffness

headaches / numbness and tingling / weakness

depression / anxiety / thoughts of suicide

ANYTHING ELSE WE SHOULD KNOW ABOUT YOU?

____

______________________________________ ______

Patient signature (or guardian/representative) Date

CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS: For the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of UMMS.

*Hereafter referred to as "PRACTICE"

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of PRACTICE. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either physician practice care and medical and/or surgical treatment or examinations. If applicable, I give PRACTICE permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize PRACTICE to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

INDEPENDENT CONTRACTORS: I understand that some healthcare providers providing services to me may not be employees of PRACTICE. Some healthcare providers providing services to me may be independent contractors who have been granted the privilege of using the practice facilities to provide services for and on behalf of PRACTICE. I understand that if the employment status of a healthcare provider is important to me in making treatment and other healthcare decisions, I may inquire as to the employment status of the healthcare provider caring for me.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to PRACTICE all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the practice is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by PRACTICE, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.1

PRIVACY OF INFORMATION: (Please check √ one)

____I **ACKNOWLEDGE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information; or

____I **REFUSE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within PRACTICE, I consent to the program disclosing these records to others within PRACTICE and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of PRACTICE or other affiliates of University of Maryland. I may revoke this consent at any time except to the extent that the program, PRACTICE, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees, collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize PRACTICE and its agents to:

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to PRACTICE at any time associated with me or my account;
b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at PRACTICE or services received at PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by PRACTICE or services to be provided by PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify PRACTICE if any telephone number, email address or other unique electronic identifiers or modes that I provided to PRACTICE change or are no longer used by me.

COVID-19: This practice is one of the places where patients have come to receive COVID-19 care. I understand that patient care and treatment decisions may be impacted as resources become affected due to our response to COVID-19. I understand that in an effort to limit unnecessary contact, providers may be augmenting their care with the use of telemedicine and other communication methods that the provider deems appropriate. I am aware that as with the use of any technology, the risk of equipment or security failures can exist despite best efforts. I further understand that although proper interventions are in place to minimize the risk of COVID-19 transmission, the ability to completely remove the risk is not possible. I understand this risk and consent to be treated at this facility.

I CERTIFY THAT I HAVE READ THIS CONSENT AND AM THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR AM DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. BY SIGNING BELOW, I REPRESENT THAT THE INFORMATION GIVEN BY ME IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

______________________________ ______________________________

PATIENT OR RESPONSIBLE PARTY NAME RELATIONSHIP TO PATIENT

PRINT NAME	WITNESS (SIGNATURE)

DATE	TIME

REASON IF UNABLE TO SIGN:
_____ PHYSICAL CONDITION _____ MENTAL CONDITION

TO BE USED FOR VERBAL CONSENT:
ON ____________________ AT ____________ O'CLOCK,
DATE TIME

____
PRINT NAME OF PERSON GIVING CONSENT

THE TERMS OF THIS CONSENT WERE REVIEWED WITH THE PATIENT, PARENT OR GUARDIAN OF THE PATIENT OR THE DULY AUTHORIZED AGENT OF THE PATIENT VERBALLY AND SUCH INDIVIDUAL PROVIDED VERBAL CONSENT TO THE TERMS SET FORTH HEREIN.

PRINT WITNESS NAME	WITNESS SIGNATURE

PRACTICE complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PRACTICE does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PRACTICE provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that PRACTICE has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance and Business Ethics Group, 900 Elkridge Landing Road, First Floor, Linthicum, MD 21090, 410-328-4141, compliance@umm.edu.You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

UNIVERSITY *of* MARYLAND
BALTIMORE WASHINGTON MEDICAL GROUP

Authorization to Disclose Health Information
(Excluding Medical Records/PHI)

Patient Name: ______________________ **Date of Birth:** ____________ **Date:** __________

Authorization to Disclose Health Information

I, ______________________, grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name	Relationship

______________________________ ______________
Patient or Responsible Party Signature **Date**

______________________________ ______________
Patient / Responsible Party Name **Relationship to Patient**