CLIFTON PARK ADVANCED IMAGING, PLLC
648 PLANK RD.
CLIFTON PARK, NEW YORK 12065

Patient Name: ______________________________ Date: ___/___/___

Address: ____
Street City/State Zip Code

DOB: ___/___/___ Tel.: (____) _____-________

Insurance Policy Holder (Person): ______________________ DOB: ___/___/___

Address (if different from above): ______________________________

Patient Insurance Waiver and Notice of Responsibility

As a consumer of medical service, you may have an agreement with an insurance carrier to assist with payment of your medical care. Albany Advanced Imaging, P.L.L.C., maintains agreements with various insurance carriers. Should we participate with your insurance carrier, we are happy to bill your insurance provider directly. Your signature on this form today authorizes us to do so. If your insurance carrier (for whatever reason) chooses not to satisfy your bill in full, you understand and accept complete personal responsibility for any payment due.

Some insurance companies require your doctor to obtain approval before imaging is performed. Albany Advanced Imaging, P.L.L.C. is not responsible for obtaining or justifying pre-certification, authorization or approval. Your signature authorizes Albany Advanced Imaging, P.L.L.C. to perform the examinations(s) requested by your doctor. Albany Advanced Imaging, P.L.L.C. is not responsible in any way should your insurance carrier deny payment for your examination.

Initial Here ____________________

Receipt of Notice of Privacy Practices ***POSTED ON WALL***

I have been informed of the Notice of Privacy Practices from Albany Advanced Imaging, P.L.L.C. concerning how the use of disclosure of Protected Health Information will be handled by the practice. This notice is posted in the office reception area. I understand I can also receive a copy of this notice.

(initial here) ____________________

Signature: ______________________________ Date: ___/___/___

Your relationship to the patient (if applicable) ______________________

CPAI PATIENT WAIVER.doc
Revised on 07/29/15

Clifton Park
Advanced Imaging
THE RADIOLOGY SPECIALISTS

Bone Densitometry Questionnaire

Patient Name: ______________________________

Ethnicity: ☐ Black ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Native American ☐ Other __________

Have you had a bone density study before? ☐ Y ☐ N

If yes, Where: ____________________ When: ______________

Please list all medications and/or vitamin supplements? ______________________

____

Has your Mother or Father suffered a hip fracture? ☐ Y ☐ N

Current smoker? ☐ Y ☐ N

Do you consume 3 or more alcoholic beverages per day? ☐ Y ☐ N

Any chance of pregnancy? ☐ Y ☐ N

Which of the following best describes you? ☐ Pre-menopausal ☐ Post-menopausal

Do you currently have or have you had any of the following:

☐ Gastrointestinal Disease ☐ Hyperparathyroidism ☐ Diabetes
☐ Liver Disease ☐ Kidney Disease ☐ Eating Disorders
☐ Organ Transplant ☐ Skeletal Abnormalities ☐ Alcoholism
☐ Rheumatoid Arthritis

Have you had any fractures (broken bones)? ☐ Y ☐ N

If yes, what bones were fractured and when? ______________________________

Have you ever had surgery on your hip or spine? If yes, please explain in detail______________

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Revised 10/28/11