Frederick F. Buechel, Jr. MD
Robotic Joint Center™
737 Park Avenue, Suite 1C
New York, New York 10021

ROBOTIC™ JOINT CENTER BUECHEL

Reset & Clear All Data

Patient Registration Information

Patient Name: Last_____ First_____ **Today's Date**_____

Date of Birth_____ **Age**_____ **Social Security#**_____

Marital Status_____ **Gender** ☐ Male ☐ Female

Home Address:
Address_____ Apt_____
City_____ State_____ Zip_____

Contact information:
Home Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____
Work Phone: ( ) _____-_____
email:_____

Business Information:
Profession_____
Employer_____

Business Address:
Address_____ Apt_____
City_____ State_____ Zip_____

Primary Insurance:
Insurance Company: _____ Policy #_____
Policy Holder_____ Group #_____
DOB_____ SS#_____

Secondary Insurance
Insurance Company: _____ Policy #_____
Policy Holder_____ Group #_____
DOB_____ SS#_____

Primary Care Doctor: Name_____ Phone # ( ) _____-_____
Address_____

Referred By:_____ (doctor, friend, therapist, relative, patient, website, internet)

Emergency contact: Name_____ Phone # ( ) _____-_____
Relationship_____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Signature: _____ (self / legal guardian)

Office use only:
MRI Precert Lower (73721): ☐ necessary ☐ not necessary ☐ Self-pay ☐ HMO

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I hereby authorize the Robotic Joint Center / Frederick F. Buechel, Jr. MD to **release** any information acquired in the course of my examination and treatment to my insurance company and/or employee health benefit plan, to process insurance claims and allow a photocopy of my signature to be used for this purpose. This order shall remain in effect until revoked in writing.

Signature _____

Date _____

I hereby **consent to medical care**, tests and examinations necessary for me determined by the Robotic Joint Center and Frederick F. Buechel, Jr. MD.

Signature _____

Date _____

I also **authorize payment** to the Robotic Joint Center and Frederick F. Buechel, Jr. MD for the surgical and/or medical benefits due under the terms of my insurance and/or employee health care benefit plan.

Signature _____

Date _____

I am **aware** that my insurance company and/or employee health care **benefit plan may or may not pay** for durable goods (i.e.: braces, bandages, crutches, canes, walkers, etc.).

Signature _____

Date _____

I **consent to** and authorize the Robotic Joint Center and Frederick F. Buechel, Jr. MD the use of **electronic media**, including email and text, **to contact me** regarding all aspects of my treatment and test results for the duration of my time as a patient until otherwise notified without encryption.

Signature _____

Date _____

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Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of its Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient signature _____ Date _____

Office Use Only

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below:

Date _____ Inititals _____ Reason _____

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Patient Insurance Coverage Agreement

Dear Patient:

We have verified your commercial insurance and would like to make sure you fully understand your benefits. Please take a moment to review the following information.

☐ Surgical procedures are subject to pre-certification

☐ MRI's may be subject to pre-certification and require a co-payment

☐ Your plan may have a calendar year /contract year deductible to be satisfied

☐ Your plan may have a Health Savings Account which will cover a portion or all of your fees

$_____ Payment is due for Specialist Office visit

- We will be billing your insurance carrier for your office visit. The patient payment is due at the time of service.
- Please be aware that your insurance may send the Robotic Joint Center / Frederick F. Buechel, Jr. MD's reimbursement check directly to you for the care and services you received from him.
- Please note that the check will be issued in the name of the insured person; however, the monies contained in the check are the payment to Frederick F. Buechel, Jr. MD for his services.
- It is very important that when you receive these checks you endorse them by signing them on the back and writing "Pay to the order of Frederick F. Buechel, Jr. MD", beneath your signature.
- Please then send the check, along with the attached "Explanation of Benefits" (EOB), to our office so your account is credited properly. You may also alternatively choose to deposit the check and pay by cash or credit card. Please call our office at 212-308-3089, and we will take care of this for you.
- If you have any questions regarding billing please contact us at any time and we will be happy to review any concerns you may have. In the event that you overlook the forwarding of insurance company payments we will contact you to follow up.

I have read and understood this agreement.

Patient Signature _____ **Date**:_____

Patient Name: _____

Credit Card on File
We offer a credit card on file option for payment of fees, deductibles, co-payments and co-insurances.

Card Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover **Security Code**** _____

Card # _____ **Exp**. _____

Name on Card _____

Signature of Card Owner _____ **Date** _____

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Patient Agreement

Welcome! Please take a moment to read and sign the following agreement; it lays out our billing and scheduling procedures. If you have any questions, please ask for clarification.

- Patients are responsible for scheduling and confirming appointments with the front desk. A confirmation telephone call or e-mail will be sent to you the day before your appointment in an attempt to confirm your appointment for the next day.

- Patient portion of payment is expected at the time of service. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payment or any claims denied by your insurance carrier. Having insurance does not absolve you from your responsibility to ensure that bills from provider are paid in full. The Robotic Joint Center and Frederick F. Buechel, Jr. MD are not contracted with your insurance.

- I hereby authorize payment of medical benefits directly to the Robotic Joint Center / Frederick F. Buechel, Jr. MD for all services rendered. I assign rights and obligations I may have under my plan to the provider and representatives with the power to file claims, appeals and grievances on my behalf including litigation if necessary.

- I hereby authorize the Robotic Joint Center / Frederick F. Buechel, Jr. MD, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit. Failure to do so may result in my being responsible for the full amount of all services rendered.

- In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to the Robotic Joint Center / Frederick F. Buechel, Jr. MD all rights, title and interest in the benefits payable for services rendered by the Robotic Joint Center / Frederick F. Buechel, Jr. MD provided by my insurance policy and/or employee health benefit plan.

- I hereby authorize my insurance carrier to pay directly to the Robotic Joint Center / Frederick F. Buechel, Jr. MD all benefits due under the policy. If the Robotic Joint Center / Frederick F. Buechel, Jr. MD or its authorized agents are unable to collect payment for services rendered herein, or if I fail to forward any and all monies received by me from my insurance carrier for rendered services and if a Collection Agency must be used, I will be responsible for all collection costs and/or attorney's fees incurred, in addition to interest at 10%, accruing on the last business day of the month, following a 90 day grace period from the date of service.

- The Robotic Joint Center / Frederick F. Buechel, Jr. MD also reserves the right to refer the full amount of the billed services to the collection agency.

- A photostatic copy of this authorization shall be considered as effective and as valid as the original contract.

I have read and understood this agreement.

Patient Signature _____ Date _____

Patient Name _____ Date of Birth _____

Submit Form via Email