Bucher Medical Services, S.C. - PATIENT REGISTRATION FORM

Please complete the following confidential information

How did you hear about us, who referred you to us?

Patient's Name: _____
First MI Last Nickname

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Male to Female ☐ Female to Male

Patient's Date of Birth: _____ Age:_____ Patient SS#: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Address: _____
Street City State Zip

Please provide a phone number where we could leave detailed messages at: (____) _____ - _____

Alternative number: (____) _____ - _____

Employer: _____

E-mail: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Significant Other

EMERGENCY CONTACT INFORMATION

_____
First Last Relationship Phone

The name of my Insurance Company is:

_____ _____
Primary Insurance Company **Secondary Insurance Company**

Patient Signature: _____ Date: _____

PATIENT TREATMENT CONSENT FORM

I hereby give my permission and consent for Gary Bucher MD and staff to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I also understand that the High Resolution Anoscopy (HRA), which is the examination and evaluation of my anal canal, is considered a surgical procedure.
You are being seen by Dr. Bucher because your doctor has referred you to Dr. Bucher and/or because you are experiencing symptoms that could be related to Anal Dysplasia. Your visit with Dr. Bucher is not a screening or preventative visit. I assume full responsibility should I provide inaccurate, incomplete or misleading information.

I certify that the identifying information, addresses, telephone information, and e-mail address that I have provided is correct.

I certify that the insurance information that I provided is correct and up to date.

I agree to inform Gary Bucher MD and staff if such information changes or becomes outdated. I understand that the office of Gary Bucher MD cannot contact me if I have provided incorrect or illegible information or should I not keep this information current and correct.

Patient Name: _____ DOB:_____
(Please Print)

Patient Signature:_____

Date: _____

Dr. Gary Bucher and his Staff Want You To Know How We Will Protect Your Private Health Information.

When you visit the medical practice of Dr. Gary Bucher (Bucher Medical Services S.C.) it is very important that you feel safe in telling Dr. Bucher your personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA was updated on September 01, 2013. HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance the need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice makes available a copy of the "Notice of Privacy Practices", which is available/displayed in the reception/waiting room area. The Notice describes how the medical information we receive from you maybe used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of that Notice for your review. You are entitled to a personal copy of that Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of Bucher Medical Services, S.C. Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____ Date: _____
(Please Print)

Signature of Patient or Personal Representative: _____

If Personal Representative, give relationship to patient: _____

Bucher Medical Services, S.C. **(BMSSC)**
Practice & Financial Policies

We are happy that you selected the SPECIALTY medical practice of Dr. Gary Bucher.
We are committed to the success of your medical treatment and care.

We know that insurance coverage can be very confusing. We are here to assist you as much as we can. To protect you, our patient and us/BMSSC, we have put in place our Practice & Financial Policies, which outline your financial responsibilities in relation to your medical care provided by BMSSC. By initialing each paragraph and signing and dating this document, I, the patient, acknowledge to have read, understood and accept these Practice Policies.

1. *BMSSC* will submit claims to my health insurance company on my behalf, and then bill me later for any parts of the claim that are my responsibility as dictated by my health insurance plan, such as deductible, co-insurance, or services provided that may not be covered by my insurance plan. It is my responsibility to understand my own Health Insurance Policy. I also understand that the High Resolution Anoscopy (HRA), which is the examination and evaluation of my anal canal, is considered an out-patient, in-office surgical procedure. _____

2. Should Bucher Medical Services S.C. have not received an Explanation of Benefits (acknowledgement of claim receipt) from my Insurance within 45 days of submitting my claim, the claim balance will become my responsibility. BMSSC cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. _____

3. It is my responsibility to inform *BMSSC* of any health insurance coverage changes as soon as they occur. Any un-paid or denied office charges by my health insurance due to my neglect of not providing *BMSSC* with my most current health insurance information will become my financial obligation. _____

4. I will inform *Bucher Medical Services S.C.* of any home address & contact information changes as well as credit card information & billing address changes. _____

5. We will make every effort that you will be seen/treated by the same provider on your follow up visits, but I understand that there may be times when my regular provider is not available and that I will then be seen/treated by any provider, that is employed by BMSSC. _____

6. In very rare circumstance, due to unforeseen circumstances, it may become necessary for BMSSC to move my appointment to a different timeslot or a different day. BMSSC will contact me in advance, by calling my phone number on file. _____

7. All office visit co-pays are due at time of service. _____

8. Should I arrive too late for my scheduled appointment, it will be at *BMSSC's* discretion if I need to re-schedule my appointment and/or if I will be charged for a NO-SHOW. _____

9. BMSSC will invoice me $125.00 if I NO-SHOW for any of my appointments. _____

10. NO-SHOW invoices/statements are due upon receipt and should such NO-SHOW invoice not be paid by me, by the printed due date, BMSSC will transfer my account to a collection agency. _____

11. It is MY own responsibility to remember when my appointment times are. It is NOT the responsibility of *BMSSC to call me and remind me of my appointment times*. If I have a true emergency that would make it impossible for me to keep my appointment, I will call BMSSC, and only then will the no-show fee be waived. I also acknowledge that BMSSC does not communicate for the purpose of scheduled appointments via Text/Twitter/Facebook/e-mail. _____

_____ _____ _____
Patient Name-PRINT PT Signature Date

(continue on page 2)

(BMSSC) Practice & Financial Policies, (continued)

12. ***Bucher Medical Services, S.C.* will mail me a detailed invoice outlining my charges, which are due upon receipt.** Should I have not paid my invoice within 90 days of the statement issue date, (we do NOT distribute patient statements on a monthly basis), my account will be transferred to a collection agency and I will no longer be able to be seen by BMSSC. _____

13. Should I have a prior balance due to *BMSSC* at the time of my next visit, *BMSSC* will ask me to pay the full amount at that time. ____

14. I will be responsible for my returned check fees and resulting fees to *BMSSC* (NSF). _____

15. Should I opt to no longer receive medical care through BMSSC and I request my medical records to be transferred, I authorize *Bucher Medical Services, S.C.* to charge my credit cards on file for any outstanding balance I owe. *BMSSC* reserves the right to refuse services to established patients who have not met their financial obligations such as outstanding account balances that are older than 90 days or unpaid balances over $ 200.00 ____

16. For the health and safety of our patients, **BMSSC has a No-Pets policy.**

Although we love animals, we ask that you please leave your pet at home during your visit to BMSSC.
This No-Pets policy applies to: Pets, Emotional Support Animals, Comfort Animals, Therapy Animals.
BMSSC complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.
Pets/Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. Under ADA regulations that became effective on March 15, 2011, there are no protections for emotional support animals in terms of access to public accommodations and public entities. The Department of Justice has stated that emotional support animals are not protected as service animals under these regulations.
Should you arrive to an appointment with a pet that is not a service animal, you will be asked to remove the animal from our healthcare facility. To avoid any disruption or inconvenience, we ask that you please leave your pet at home. _____
Thank you for your cooperation and consideration of all our patients.

Should I not agree and not accept the outlined BMSSC policies, BMSSC reserves the right to refuse me as a patient. ____

_____
Today's Date

_____ / _____
Visa/Master Debit/Credit Card # Exp. Date

_____ / _____
Name as it appears on Card (Please Print) **Cardholder Signature**

_____/_____/_____/_____
Street address, where you receive your credit card statement City State Zip