Asthma & Allergy Physicians of Rhode Island

Statement of Financial Responsibility / Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Asthma & Allergy Physicians of Rhode Island. I assign and authorize payments to Asthma & Allergy Physicians of Rhode Island. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am not responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal Law.

Signature of Patient or Guardian:____ Date:_________________

Printed Name of Patient and/or Guardian:_____________________________ Relationship to Patient:______________