Asthma & Allergy Physicians of RI, Inc.
Update Sheet

Full Name:_____ Date of Birth:_____ Gender:_____

Address:_____ City:_____ State:_____ Zip Code: _____

Telephone: (Home)_____ (Work)_____ (Cell) _____

Race: White_____ Hispanic_____ Non-Hispanic African American_____ Native American_____
Asian_____ Other_____ Prefer not to answer_____

Social Security : ----------_____(required) Email Address: _____

Employed by:_____ Spouse, Parent, Guardian Name: _____

Primary Care Physician_____ Referring Physician_____

Primary Insurance:_____ ID:_____ Effective Date: _____

Insured's Name:_____ Date of Birth:_____ SSN# _____

Secondary Insurance:_____ ID:_____ Effective Date: _____

Secondary Insured's Name:_____ Date of Birth:_____ SSN#_____

Insured's Employer (Primary)_____ Secondary: _____

Emergency Contact:_____ Phone:_____ Relationship: _____

I authorize AAPRI to forward progress reports to my PCP and/or referring providers as needed.
Yes_____ No_____ Initial _____

Consent for Healthcare of Minor:

By signing below, I give consent for AAPRI to treat my son/daughter in the event that a parent or legal guardian is not able to accompany him/her to the appointment, but if he/she is accompanied by a responsible adult who represents me. This may include, but not necessarily be limited to: physical exams, skin testing, allergy injections and issuing prescriptions in my absence. This agreement will be in effect until revoked by me in writing.

Signature of Parent or Guardian:_____ Date: _____

Billing Procedure:

This office participates with most insurance carriers in the state, as well as several carriers out of state. If you have health coverage with any of these carriers, we will automatically bill them for their contracted portion of you care. In most other situations we will provide you with a copy of your encounter form, which you may then submit to the carrier for reimbursement, the encounter form has the information required by most insurance companies. Your signature is required in all cases where we will be submitting on your behalf to the carrier.

Signature:_____ Date:_____

Asthma & Allergy Physicians of Rhode Island

☐ I authorize Asthma & Allergy Physicians of RI to give me access to their secure patient portal. I understand that I will be able to send messages to my provider, and have access to the notes from my office visits. My email address is: _____

☐ I give Asthma & Allergy Physicians of RI to contact me by text message at the following number:

_____**OR**

☐ I do not wish to be texted.

☐ I would like to receive AAPRI's monthly e-newsletter (It contains great information!)
My email address is:_____

Appointment Cancellation Policy Agreement:

Asthma & Allergy Physicians of RI is committed to providing exceptional patient care, including doing our best to accommodate everyone's scheduling needs. If you are unable to keep your appointment, **please call us at (401)-751-1235 by 12:00 PM (noon) the day prior to let us know**. For Monday appointments, please call by noon on *Friday*. If prior notice is not given, **you will be required to pay a missed appointment fee of $50.00.** This fee is not covered by your insurance company, and will be considered an out-of-pocket expense. Please note that if you frequently cancel or reschedule appointments, we reserve the right to release you from our care.

Copays & Payments

We make every effort to avoid any misunderstandings regarding your medical insurance. Please be aware that the amount that you are quoted may be an **ESTIMATE ONLY.** It is the patients' responsibility to know and understand their insurance copayments and limitations, but our staff is happy to work with you and your insurance company to get the most accurate information. Any balances not paid by your insurance company are your responsibility. By signing below, you are acknowledging that you have read and understand our office policies.

Name:_____**Date:** _____

Credit Card # for Missed Appointment Fee: _____

Exp:_____**CVV:** _____

Signature: _____

Asthma and Allergy Physicians of Rhode Island, Inc.

Research Division

AAPRI Clinical Research Institute

470 Tollgate Road

Warwick, RI 02886

401-681-4960

One of the ways Dr. Zwetchkenbaum stays on top the "State of the Art" treatments is his involvement in Clinical Research Studies. Clinical Trials involve people like you who volunteer to participate in carefully conducted investigations that ultimately uncover better ways to treat, prevent, diagnose and understand human disease.

Ninety percent of our patients who participate request to be involved in additional trials. Answering *yes* only allows us to contact you, if you may be eligible to participate, per study criteria. It *does not* commit you to participating.

Asthma and Allergy Physicians of RI may use your protected information to aid in identifying whether you may qualify for a research study conducted by our Research Division. We will only contact you to discuss the option of enrolling in a clinical study that you may qualify for.

Would you like to be contacted if you may criteria for a study?

(Please check one)

☐ Yes, I would like to be contacted if I am potentially eligible

Patient's Name and DOB:_____

Home Phone:_____Cell Phone:_____call text (circle one or both)

Email:_____

Signature: _____ Date: ____/____/_____

☐ No, I would rather not be contacted, even if I were potentially eligible

Signature: _____ Date: ____/____/_____