AAPRI
Asthma & Allergy
PHYSICIANS OF RHODE ISLAND

Patient Name: _____ Date of Birth: _____ Gender: M F Other

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

Tel.: (Home): _____ (Cell): _____ E-mail: _____

Emergency Contact Name: _____ Tel.: _____ Relationship: _____

Primary Care Physician: _____ Referring Physician: _____

I, _____, authorize AAPRI to forward progress reports to my PCP and/or referring providers.

Race/Ethnicity (*please circle*): White Hispanic Non-Hispanic African American Native American Asian Other

Primary Insurance Name: _____	Secondary Insurance Name: _____
Member ID: _____	Member ID: _____
Effective Date: _____	Effective Date: _____
Guarantors Full Name: _____	Guarantors Full Name: _____
Guarantors Date of Birth: _____	Guarantors Date of Birth: _____
Guarantors Social Security Number: _____	Guarantors Social Security Number: _____

Consent for Healthcare Treatment:

By signing below, I agree to receive treatment provided by the providers at Asthma & Allergy Physicians of Rhode Island until withdrawn by signee or guardian. This may include, but not be limited to physical examination, skin and breathing tests, injections, and breathing treatments.

Signature: _____ Date: _____

Name Printed: _____ Relationship: _____

Consent for Billing, Assignment of Benefits and Acknowledgement of Financial Responsibility:

By signing below, I hereby assign all health insurance benefits and authorize payments to Asthma & Allergy Physicians of Rhode Island for services rendered. I understand that 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 acknowledge and understand that I am legally responsible for fees not paid in full, co-payments, policy deductible and co-insurance except where my liability is limited by contract or State or Federal Law.

Signature: _____ Date: _____

Name Printed: _____ Relationship: _____

Acknowledgement of Receipt of our Notice of Privacy Practice:

By signing below, I acknowledge that I have read Asthma & Allergy Physicians of Rhode Island's Notice of Privacy Practice, via office posting or requesting a physical copy, therefore I understand how my health information may be used and disclosed by "AAPRI", as well as how I may obtain access and control of my health information.

Signature: _____ Date: _____

Name Printed: _____ Relationship: _____

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Contact Agreement
(*Please check*)

☐ I give "AAPRI" permission to "web-enable" me for the Healow portal, granting me accessing my medical and account details, as well as optimal communication to the AAPRI providers and staff.

Sign up E-mail: _____

☐ I do not wish to be web-enabled, and I understand the primary means of practice communication is through the Healow portal. Resulting in reduced phone support.

Appointment Cancellation Policy Agreement

Asthma and Allergy Physicians of Rhode Island is committed to providing exceptional patient care, including doing our best to accommodate everyone's scheduling needs. If you are unable to keep any of your appointments, including testing or procedures, please contact us through the Healow portal, or at 401-751-1235, no less than 24 hours in advance. For appointments on Monday, please contact the practice by noon, the Friday before. If prior notice is not given, you will be required to pay a missed appointment fee upwards to $150.00. This fee is not covered by your insurance company and will be considered an out-of-pocket expense.

Copays and Payments Agreement

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 patient's responsibility to know and understand their insurance co-payments 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 financial responsibilities. Overdue balances may result in account deactivation, resulting in the inability to schedule new appointments. Please assist in keeping accounts up to date by providing card details below.

Name on card: _____ | Expiration Date: _____

Card number: _____ | CVV: _____

Physical copies of this registration form will be destroyed upon upload to the electronic medical records system.

By signing below, you acknowledge that you have read and understand our office policies outlined on this registration form

Signature: _____ Date: _____

Name Printed: _____ Relationship: _____