OCEAN STATE HEALTHCARE

OCEAN STATE ASTHMA & ALLERGY ASSOCIATES
PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Age:_____

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

INSURANCE INFORMATION

Primary Insurance:
Insurance Carrier:_____ Effective Date:_____

Identification Number:_____ Group Number:_____

Subscriber Name:_____ Relationship:_____

Subscriber Date of Birth:_____ Employer:_____

Secondary Insurance:
Insurance Carrier:_____ Effective Date:_____

Identification Number:_____ Group Number:_____

Subscriber Name:_____ Relationship:_____

Subscriber Date of Birth:_____ Employer:_____

GENERAL INFORMATION
Emergency Contact:_____ Phone:_____

Pharmacy:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Referring Doctor:_____ Phone:_____

Please provide the receptionist with your insurance card and photo ID so that a copy can be made for your chart.

Please sign the authorization for assignment of benefits on the reverse side of this form.

OCEAN STATE HEALTHCARE

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby request payment of medical benefits to Ocean State Asthma & Allergy. I authorize Ocean State Asthma & Allergy to release any information requested by my insurance carrier for the purpose of claim review and payment.

I understand that I may be responsible for a balance due (copayment, co-insurance, or deductible) based upon the explanation of benefits provided by my insurance carrier.

Signature:_____ Date:_____

OCEAN STATE ASTHMA & ALLERGY ASSOCIATES
PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD INFORMATION - Every time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for your future care. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment. It is a legal document describing the care you received and can be requested by your third party payer to verify services were provided.

YOUR HEALTH INFORMATION RIGHTS - Although your health record is the physical property of this facility, the information belongs to you. You have the right to request or restrict disclosure of this information. There may be a copying fee assessed for retrieval and copying of any record. You have the right to review your record with the Doctor and make physician authorized amendments.

OUR RESPONSIBILITIES - This facility is required to protect the privacy of your health information. We will not disclose your information without your authorization. Health information will be released only with a signed and witnessed release form unless otherwise indicated for continuation of care.

EXAMPLES OF DISCLOSURES FOR TREATMENT AND PAYMENT:

We will use your health information for treatment. Our staff will document all pertinent information to coordinate your care.

We will use your health information for payment. A claim may be sent to your third party payer. A bill may be sent to that guarantor indicated on your account. The information on or accompanying the bill may include information that identifies you, your diagnosis, and services provided.

We may contact you to provide appointment reminders or inform you of changes to our schedule.

We may disclose health information relating to adverse events with respect to products and product defects to the FDA.

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Workers Compensation or other similar programs established by law.

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

I HAVE READ AND UNDERSTAND THE PRIVACY PRACTICES OF OCEAN STATE ASTHMA & ALLERGY.

_____
Patient Name

_____ _____
Signature Date