



Allergy, Asthma & Immunology of the Rockies, P.C.

Robert McDermott, M.D.
 DIPLOMATE - THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY
 www.allergyoftherockies.com

2520 S. Grand Avenue Suite 209
 Glenwood Springs, CO 81601
 Appointments: 970-947-0600
 Fax: 970-947-0601

OTHER LOCATIONS:
 711 EAST VALLEY ROAD SUITE 201A
 BASALT, COLORADO 81621
 377 SLYMAN LAKE ROAD SUITE 220
 EAGLE, COLORADO 81631

Patient Registration Form

Patient Name (Last, First, Middle Initial)	Patient Date of Birth	Patient SSN
Patient Mailing Address	City/State/Zip Code	Marital Status
Home telephone number	Cell telephone number	Work telephone number
Primary Care Physician's Name*	Practice's Name	PCP's Phone Number
Primary Care Physician's Address	City/State	Zip Code
Specialist Physician's Name*	Practice's Name	Specialist's Phone Number
Specialist's Address	City/State	Zip Code
How did you hear about us: <input type="checkbox"/> Primary Care Physician Referral <input type="checkbox"/> Specialist <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet <input type="checkbox"/> Advertisement <input type="checkbox"/> Family <input type="checkbox"/> Insurance <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Other		
* I authorize AAIR, P.C. to send a written report to my above Doctors: <input type="checkbox"/> Yes <input type="checkbox"/> NO		

***For the below information, if the patient is a child, please fill out the parent/legal guardian's information. ***
If the patient is an adult, please fill out the following employment information for the patient and spouse if applicable.

Name	DOB	SSN	Name	DOB	SSN
Mailing Address			Mailing Address		
City/State/Zip		Home Phone #	City/State/Zip		Home Phone #
Employer Name		Work Phone #	Employer Name		Work Phone #
Employer Address			Employer Address		
City/State/Zip			City/State/Zip		

Emergency Contact Name
Relationship
Home Phone Number
Work Phone Number

Primary Insurance		Secondary Insurance	
Insurance Name	Group Number	Insurance Name	Group Number
Policy/Subscriber Number	Subscriber Name/DOB/SSN	Policy/Subscriber Number	Subscriber Name/DOB/SSN

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Robert McDermott, MD when he accepts assignment.

Patient Signature/Legal Guardian: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

ACKNOWLEDGEMENT

I, _____ (patient), acknowledge that I have received a copy of _____ AAIR, P.C. _____'s Notice Regarding Privacy of Personal Health Information.

Date

(Patient's Signature)



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Financial Policy

Welcome to Allergy, Asthma, & Immunology of the Rockies. It is important that all our Policies are fully understood by you to ensure you receive continuous, experienced and timely health care. Please read this policy and acknowledge your understanding and agreement with your signature. We invite you to ask questions and/or clarifications if you have any. Thank you.

I agree that:

AAIR, PC. will bill my insurance, provided all the necessary information is given to the clinic at the time of service. This includes a valid, current insurance card. If this is not available, I will be asked to pay all charges for the date's visit before I leave the office. AAIR, PC will ask to see your insurance card at every visit to ensure that we have all the proper billing data and that the card is current.

If my insurance company does not submit payment within 30 days, I understand I will be responsible for any and all outstanding balances. I am aware that my insurance carrier, rather than my physician, may deny some services for the reason of "not medically necessary" or "non-covered services, therefore, I will become fully responsible for payment of these services.

If I have asked for an estimate of cost for my visit, this will be given as closely as possible. However, since AAIR, PC is not aware of the exact number of skin tests, level of care etc. that will be needed until the physician has seen the patient; this is considered only as an estimate and not an exact charge quote.

I assume all responsibility for the deductible costs of my insurance plan. These costs will be billed to me immediately by AAIR, PC when my insurance plan states that these are my costs and not theirs.

AAIR, PC will make all attempts to collect payment from the insurance carrier; however, I am ultimately responsible for all costs associated with my visit. Though insurance coverage may be carried, it is not a guarantee of payment. I understand that if my insurance company fails to pay AAIR, PC, any remaining balance will be my financial responsibility and will be paid in full upon receiving a statement of balance. I will pay this balance within 15 days or contact AAIR, PC to make financial arrangements. I agree to allow AAIR, PC to telephone me at any of my phone numbers given to AAIR, PC to discuss any issues regarding payment of my account. A late fee of \$20.00 will be assessed if my account is not paid in 45 days. All bills must be paid in full within 57 days or my account may be sent to an outside collection agency. Once this is done, I must deal directly with the collection agency and not AAIR, PC as it is out of their hands to do anything with my account. This agency will add the appropriate fees for collection if my account is sent there. At this time AAIR, PC will cease giving care to me and my dependents.

Signature of Patient (or Legal Guardian)

Date



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Cancellation of Appointments

Our goal at AAIR, PC is to provide high quality medical care in a timely manner. In order to do so, we have had to establish an appointment cancellation policy. This policy will enable us to better utilize available appointments for our patients in need of medical care.

A scheduled appointment means that time is reserved only for you. We ask that you call at least **48** hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient in need of timely medical care. Failure to give **48** hours notice prior to cancellation may result in a "No-show" appointment fee of \$25. This fee cannot be billed to your insurance company and will be your direct responsibility.

To cancel, please call 970-947-0600 and dial 0 to speak to the front desk. Before or after regular business hours, please leave a message with your name, appointment time, reason for canceling and a phone number for us to reach you to reschedule.

Thank you for your understanding in this matter.