ASSIGNMENT OF BENEFITS/INSURANCE RELEASE

***Primary Medical Insurance* (Policy Holder's Information Only)**

Name of Insurance_____

Policy/Member # _____

Group # _____

HMO / PPO / OTHER (**NOTICE: HMO REQUIRE REFERRAL**)

Name of Policy Holder _____

Date of Birth _____ Male /Female

Relationship to Patient _____

Policy Holder's Address _____

City _____ State _____ Zip _____

***Secondary Medical Insurance* (Policy Holder's Information Only)**

Name of Insurance _____

Policy/Member # _____

Group # _____

HMO / PPO / OTHER (**NOTICE: HMO REQUIRE REFERRAL**)

Name of Policy Holder _____

Date of Birth _____ Male/Female

Relationship to Patient _____

Policy Holder's Address _____

City _____ State _____ Zip _____

***Vision Insurance* (Policy Holder's Information Only)**

Name of Vision Insurance _____

Name of Policy Holder _____

Date of Birth _____ Male/Female

ID or Social Security # _____

Primary Care Physician's Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax# _____

Prescription Refills

If you are taking medications prescribed by one of our doctors and you need a refill, please call your pharmacy first. Your pharmacy will fax over a refill request. We ask that you allow 3 business days for processing your request. Make sure you call your refill in while you still have a few days of medication remaining to get through until the prescription can be processed. My signature below authorizes the office of Dr. Becherer & Associates, LTD. to fax/ERX prescriptions to any pharmacy.

Name of Pharmacy _____ Phone/Fax # _____

Patient/Guardian Signature _____ Date _____

Patient Responsibility Statement and Notice of Privacy Policy

I, _____, understand that I am being seen by Dr. Becherer & Associates, LTD and they will bill my primary insurance based on the information I provided above.

The filing of a claim for any service rendered **DOES NOT GUARANTEE PAYMENT** from your insurance company. Billing to secondary insurance is not a service we provide; it is up to the patient to make sure claims are sent to secondary if they want them to pay a portion of the services. I understand that if my information provided above is incorrect, or I did not obtain the proper referral when required, I will be financially responsible for payment of all charges incurred for services and/or materials received. I authorize release of medical information necessary to process insurance claims and payments of medical/vision benefits when requested by the insurance company. **If any insurance is used and there are additional fees or charges owed, one billing statement will be sent at no charge. EACH ADDITONAL STATEMENT WILL BE $5.00.**

I acknowledge that I have read the Notice of Private Policy for Dr. Becherer & Associates, LTD.

Patient/Guardian Signature _____ Date_____