Assignment of Benefits/Insurance Release

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

Name of Policy Holder_____

Date of Birth_____ Male/Female

Relationship to Patient_____

Social Security #_____

Policy Holder's Address_____

City_____State_____Zip_____

Name of Insurance_____

Policy/Member #_____

Group #_____

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

Name of Policy Holder_____

Date of Birth_____ Male/Female

Relationship to Patient_____

Social Security #_____

Policy Holder's Address_____

City_____State_____Zip_____

Name of Insurance_____

Policy/Member #_____

Group #_____

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

Name of Vision Insurance_____

Name of Policy Holder_____

Date of Birth_____ Male/Female

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 the refill request, per established guidelines. We ask that you allow 48 hours for processing your request. Make sure you call your refill in while you still have a few days of medication remaining to get through the 48 hour period. My signature below authorizes the office of Dr. Becherer & Associates, LTD. to fax prescriptions to any pharmacy.

Name of Pharmacy_____ Phone/Fax #_____

Address_____

Patient/Guardian Signature_____ Date_____

Patient Responsibility Statement and Notice of Privacy Policy

I, _____, understand that I am being seen by Dr. Becherer & Associates, LTD without pre-authorization from my vision and/or medical insurance and without a referral from my Primary Care Physician.

The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. Also, having more than one insurer DOES NOT mean that your services are covered 100%. Secondary insurers will pay a fraction of what your primary carrier pays. Billing any secondary insurance is a courtesy. I understand that if my eligibility cannot be verified or if I do not obtain the proper referral form when required, I will be financially responsible for payment of all charges incurred for services and materials received from Dr. Becherer & Associates, LTD. I authorize release of medical information necessary to process insurance claims and payments of medical/vision benefits to Dr. Becherer & Associates, LTD. **Any bill which is 30 days overdue will be charged 1.5% per month service charge. If any insurance is used and there are additional fees or charges owed, one billing statement will be sent at no charge.** ***EACH ADDITIONAL STATEMENT WILL BE $6.00.***

I acknowledge that I have received a copy of Dr. Becherer & Associates, LTD. Notice of Private Policy Practice.

Patient/Guardian Signature_____ Date_____