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 Fontana Eyecare Associates to fax prescriptions to any pharmacy.

Name of Pharmacy_____ Phone/Fax #_____

Address_____

Patient / Guardian Signature_____ Date_____

Patient Responsibility Statement

The filing of a claim for any service rendered does not guarantee payment from any insurance company. Also, having more than one insurer does not mean that services are covered 100%.

I understand if my eligibility cannot be verified or if I do not obtain the proper referral when required, I will be financially responsible for payment of all charges incurred for services and materials. I authorize release of medical information necessary to process insurance claims and payments of medical / vision benefits to Fontana Eyecare Associates. A deposit is required on all materials with the balance paid in full upon delivery or shipping. Any bill which is 30 days overdue will be charged 1.5% per month service charge. In the event there is a default on payment, patient agrees to pay all expenses of collection, including, but not limited to, attorney fees and court costs.

Patient / Guardian Signature_____ Date_____