John K. Bellville, M.D.
P.O. Box 711
McMinnville, OR 97128
(971) 237-2418

ASSIGNMENT OF BENEFITS FORM

PATIENT NAME: ______________________________
BIRTHDATE:________________

Current Mailing Address:____

NAME OF **INSURANCE COMPANY**:____
(**copy of current card needed)**

INSURED'S NAME:________________________
Insured's BIRTHDATE:________________
Relationship to patient: (**Circle one**): Father Mother Self Spouse Other

INSURED'S Address (if different than patient):______________________________

INSURED'S **EMPLOYER**:____

ID or Policy Number:________________

Group Number: ________________

> I understand and authorize the release of information which ***may include drug/alcohol and/or mental health conditions***.

I hereby authorize the release of any medical information necessary to process this claim to the insurance company or specified third party payor.

*I hereby **authorize payment directly to Dr. Bellville by my insurance company** for services rendered to me and/or my dependents and understand I **am financially responsible for those charges not covered** by my insurance company.*

______________________________ ________________ ________________

Signature of patient **Date** Update: Initial/Date Initial/Date
(or legal guardian, if applicable)

revised Dec. 30, 2012