



**RITZ &
JOHNSON**
Fashion Eyecare Center

WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible vision care. To help us meet all your healthcare needs, please fill out this for completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____
 Birth date _____ SS#/SIN _____
 Name _____ Email _____
 Wishes to be called _____
 Male Female Minor Single Married Divorced Widowed Separated
 Address _____
 City _____ State/Prov. _____ Zip/P.C. _____
 Employer _____ Occupation _____
 Referred by _____
 Home Phone _____ Work Phone _____ Ext.# _____
 Cell Phone _____
 Where do you prefer to receive calls? Home Work Cell
 When is the best time to reach you? Time _____ Days _____
 In the event of an emergency, who should we contact?
 Name _____ Relationship _____ Work# _____ Home# _____

2 Responsible Party

Same as above Yes

Who is responsible for the account?
 Name _____
 Relationship to patient _____ Driver's License# _____
 SS#/SIN _____ Email _____
 Address _____
 City _____ State/Prov. _____ Zip/P.C. _____
 Employer _____ Occupation _____
 Referred by _____
 Work Phone _____ Ext.# _____
 Home Phone _____ Cell Phone _____

3 Vision Insurance

Name of Insured _____ Insurance Company _____
 Relationship to patient _____ Group# _____
 Insured's Birth date _____ Employee/Cert.# _____
 SS#/SIN _____ Ins. Co. Address _____
 Employer _____ Deductible _____
 Date Employed _____ Amount already used _____
 Occupation _____ Max. annual benefit _____

4 Additional Insurance

Name of Insured _____ Insurance Company _____
Relationship to patient _____ Group# _____
Insured's Birth date _____ Employee/Cert.# _____
SS#/SIN _____ Ins. Co. Address _____
Employer _____ Deductible _____
Date Employed _____ Amount already used _____
Occupation _____ Max. annual benefit _____

5 Do you . . .

Do you.. (Check _____ if your answer is yes)

- _____ Work at a computer?
_____ Notice glare from the computer or lights at night while wearing your glasses?
_____ Think you might benefit from thinner, lighter lens design?
_____ Prefer not to wear glasses at times?
_____ Spend time outdoors? How many hours a week?
_____ Have prescription sunglasses?
_____ Have more than 1 pair of current RX glasses?
_____ Have other family members who would benefit from a visual evaluation?

If you wear bifocals, do the lines or head tilting bother you? _____ Yes _____ No

If you wear contact lenses, are you satisfied with the vision and comfort? _____ Yes _____ No

Eye Background

Date of last Eye Exam _____ By Whom? _____
Have you ever tried contact lenses? _____ Yes _____ No
Do you currently wear contact lenses? _____ Yes _____ No
What Kind? _____ Solution Used _____

Are you interested in:

Contact Lenses to change the color of your eyes? _____ Yes _____ No

Daily Disposable Contact lenses? _____ Yes _____ No

Overnight wear of contact lenses? _____ Yes _____ No

6 Financial Authorization/Release

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED - We accept cash, personal checks, MasterCard, Visa and Discover. Returned checks are subject to a \$30.00 service fee and will result in a loss of check writing privileges in our office.

Accounts not paid by your insurance carrier after 90 days of filing, become the financial responsibility of the patient and is due in full, unless a written statement is received from the insurance carrier with a valid denial on the transmitted claim.

Accounts not paid within 90 days will be sent to TransWorld Collections. All fees incurred with collections proceedings become the financial responsibility of the account responsible.

CHILDREN OF DIVORCED PARENTS-Payment is due at time of service no matter who is responsible by order of the divorce decree.

I request that payment of Authorized Medicare benefits or other insurance be made on my behalf to Drs. Ritz and Johnson for any services/materials furnished by them to me. I authorize Drs. Ritz and Johnson, as holders of medical information about me, to release to the Health Care Financing Administration and Services as needed. I realize that I am responsible for any charges not covered by my insurance.

NOTICE OF PRIVACY PRACTICES POLICY ACKNOWLEDGMENT

X _____
Signature of patient or parent/guardian if minor Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.