Ritz & Johnson
FASHION EYECARE CENTER

Thank you for choosing Ritz and Johnson as your eyecare team.

We don't like paperwork either, therefore we have tried to make this form as brief as possible. Please take a few moments to provide us with this small amount of information so we can better serve you.

Personal Information

First & Last Name _____ Driver's License #_____

Birth Date ____/_____/_____ SS# _____-_____-_____ Gender _____

Address _____ City _____ State _____ Zip _____

Cell Phone (_____) _____ Alternate Phone (if applicable) (_____) _____

Email _____ Patient's Occupation _____

Primary Care Doctor/Clinic: _____ Preferred Pharmacy _____

Emergency Contact _____ Phone (_____) _____ Relationship To Patient_____

Best Method To Contact You

Please let us know what is your preferred method for our clinic to stay in communication with you. This helps us notify you when your eyewear is ready to be picked up, send you appointment reminders, electronic forms, and other clinic communications that allow us to return your messages faster.

(Please circle one) Text Message Email Phone Call Do Not Contact me

**Please note that if you choose "Do Not Contact Me" we will not be able to call, email, or text you regarding your eyewear or appointments.*

Financial Agreement and Responsibility

The patient is responsible for charges associated with Insurance co-pays or non-covered charges and is responsible for any costs associated with collections of patient balances including $25.00 return check charge. Patient statements are mailed monthly. The patient is responsible for making a payment per the due date of the statement. Please note that failure to pay for treatment and care for services rendered will result in collection actions being taken to collect the debt (including collection agency fees, return check fees, etc.).

By my signature below, I hereby authorize the assignment of financial benefits directly to Ritz and Johnson Fashion Eyecare Center and associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I authorize Ritz and Johnson Eyecare Center, as holder of medical information about me, to release it to the Health Care Financing Administration as needed.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Patient or Guardian Signature _____ Print Patient Name _____

Today's Date ____/_____/_____ Print Guardian Name (if applicable) _____

Ritz & Johnson
FASHION EYECARE CENTER

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

HIPAA Acknowledgement / Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information only to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g. patient's insurance company)
- The day-to-day healthcare operations

I have also been informed of and given the right to review and obtain (upon request) a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent in writing at any time, except to the extent that Ritz and Johnson Fashion Eyecare Center has taken action relying on this consent.

Print Patient Name _____ **Patient or Guardian Signature** _____

Today's Date ____/____/_____ **Print Guardian Name (if applicable)** _____

The following individual(s) has/have my authorization to access my Protected Health Information:

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____