VISION SOURCE®

OPTOMETRIC VISION CENTER

Dr. John T. Rietz

Patient:

Name: _____ Date of Birth_____ SSN _____

Preferred name _____ Gender: Male ☐ Female ☐ Marital Status **M S W D**

Mailing Address _____ City _____ State_____ Zip _____

Home phone _____ Cell phone _____ Email _____

Employer _____ Occupation_____ Work phone _____

Name of Parent/Spouse _____ Referred by _____

Race: (check one)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ White

Ethnicity: (check one)

- ☐ Hispanic or Latino
- ☐ Native Hawaiian
- ☐ Not Hispanic or Latino

Insurance:

Vision Insurance _____ ID# _____ Grp# _____

Medical Insurance _____ ID# _____ Grp# _____

Authorization for Release of Information:

Authorized Recipient: _____ Relationship _____

Authorized Recipient: _____ Relationship _____

FOR OUR OFFICE TO SUBMIT YOUR INSURANCE AND/OR MEDICARE YOU MUST SIGN BELOW

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Optometric Vision Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____

Signature Date

PRIVACY POLICY

I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information. I also understand that a copy of this **Notice of Privacy Practices** is posted in the waiting/reception area for my review and that I may request my own copy. **By signing below, I agree that I have reviewed and understand the information above and have reviewed or received a copy of the Notice of Privacy Practices.**

_____ _____

Signature Date

Printcraft Printing