VISIONARY EYE

Patient Name:_____ Date Completed:_____

PATIENT INFORMATION:

Prefix ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other _____ **Gender** ☐Male ☐Female ☐Other _____

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #:_____

Race ☐Black/African ☐Asian ☐White ☐Hispanic/Latino ☐Decline

Email Address: _____

Preferred Contact: ☐Text ☐Email ☐Call ☐Ok to leave a message ☐Don't leave a message

Patient Marital Status: ☐Single ☐Married ☐Divorced ☐Other _____

How did you hear about us? ☐Primary Care Provider ☐Ophthalmologist ☐Optometrist ☐Friend _____
☐Google ☐Facebook ☐Online Search_____ ☐Other _____

Referred by: _____ **Your Optometrist:** _____
Were you referred by your Optometrist ☐Yes ☐No ☐N/A

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

Patient Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Active Military ☐Student

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Type of Plan: ☐PPO ☐HMO ☐Other

ID #: _____ Group #: _____

Policy Holder's Last Name: _____ First Name: _____ MI: _____

Policy Holder's DOB: _____ Social #: _____ ☐M or ☐F

Employer Name: _____ Phone #: _____

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child

Secondary Insurance Carrier: _____ Type of Plan: ☐PPO ☐HMO ☐Other

Policy Holder's Last Name: _____ First Name: _____ MI: _____

Policy Holder's DOB: _____ Social #: _____ ☐M or ☐F

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child

VISIONARY EYE

Patient Name:_____ Date Completed:_____

Signatures on File, Assignments of Benefits, Financial Agreement:

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to VISIONARY EYE SURGERY for services furnished me by VISIONARY EYE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. VISIONARY EYE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to VISIONARY EYE, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** VISIONARY EYE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to VISIONARY EYE for reimbursement for services rendered, and (2) any health care provider for continued patient care. VISIONARY EYE may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that VISIONARY EYE maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that VISIONARY EYE has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by VISIONARY EYE if I belong to a plan that does not appear on the above mentioned list.

_____ _____ _____

Signature of Patient/Legally Authorized Person Date Time

Visionary Eye No Show Policy:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Visionary Eye sends text message and email reminders 3 days, 2 days, and 2 hours in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $35.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. I understand the "no-show" policy of Visionary Eye and agree to provide a credit card number, which may be charged $35.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided.

Patient Signature: _____ Date: _____

VISIONARY EYE Patient Name:_____ Date Completed:_____

Visionary Eye Patient Financial Policy:

Thank you for choosing us as your primary ophthalmology provider. We are committed to providing you with quality eye care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please take note of the following points:

1. **Insurance Participation:**
   - We participate in most insurance plans, including Medicare. If you are insured by a plan, we do business with, payment in full is expected at each visit.
   - If you are not insured by a plan, we do business with, payment in full is expected at each visit.
   - If you have an up-to-date insurance card, we can verify your coverage. Otherwise, payment in full is required.
   - It is your responsibility to know your insurance benefits. Feel free to contact your insurance company for any coverage-related queries.

2. **Co-payments and Deductibles:**
   - All co-payments and deductibles must be paid at the time of service.
   - This arrangement is part of your contract with your insurance company.
   - Failure to collect co-payments and deductibles can be considered fraud.

3. **Payment Methods:**
   - We accept Visa, MasterCard, American Express, Money Order, Cash and checks.
   - A returned check incurs a $35 charge, payable by cash or money order.

4. **Proof of Insurance:**
   - Complete our patient information form before seeing the doctor.
   - Provide any copy of your driver's license and current valid insurance for proof of insurance.
   - Incorrect insurance information may result in responsibility for the claim balance.

5. **Claims Submission:**
   - We will submit your claims and assist you in getting them paid.
   - Your insurance company may require direct information from you.
   - The balance of your claim remains your responsibility, regardless of insurance payment.

6. **Coverage Changes:**
   - Notify us if your insurance changes before your next visit.
   - We'll make appropriate adjustments to help you receive maximum benefits.

7. **Refund Policy:**
   - Accounts are reconciled at the end of each quarter. If a refund is due, it will be refunded ONLY to the card used at the time of service or a check can be issued.

8. **Non-Covered Services:**
   - Some services may not be covered by Medicare or other insurers.
   - You must pay for these services in full at the time of visit.

Remember, your insurance benefit is a contract between you and your insurance company, and we are not party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Patient Signature: _____ Date: _____

VISIONARY EYE

Patient Name:_____ Date Completed:_____

Authorization to Disclose Private Healthcare Information:

I, _____, do authorize Visionary Eye to release information including the diagnosis, records, examination rendered to me, and claims information. Information may be released to:

- ☐ My spouse, _____
- ☐ On my voicemail, _____
- ☐ In a text message to my cell phone, _____
- ☐ My email, _____
- ☐ My friend, _____
- ☐ Other, _____

_____ _____

Patient Signature Date of Birth

Acknowledgement of Notice of Privacy Practices:

By signing this form, you acknowledge that you may request a copy of the *Notice of Privacy Practices* of Visionary Eye. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I acknowledge the *Notice of Privacy Practices* of Visionary Eye.

_____ _____

Patient Signature Date of Birth

Patient Name (Please Print)

REFRACTION POLICY

- The test that is performed to determine your eye glass prescription is called a refraction.
- In order for a refraction to be done you have to ask upon scheduling your appointment, not at the time of service.
- A refraction is considered a non-medical service, and for that reason is NOT covered by most medical insurance carriers.
- Some health plans have supplemental vision care coverage; if so, the refraction may be covered under the vision plan of your health coverage.
- If a glasses prescription is given to you, there will be a refraction charge of **$50.00** payable at the time of service.
- Please be aware that a referral from your primary care physician does not guarantee coverage for a refraction.
- We do not accept any vision plans.
- Please call your insurance carrier to find out whether or not you have vision care coverage.

Signature _____ Date_____

VISIONARY EYE

Comprehensive Visionary Eye Screening Evaluation

- At Visionary Eye Surgery, we believe every patient deserves the most comprehensive, preventative, and technologically advanced evaluation of their eye health. These non-covered imaging tests provide a complete structural baseline of your eyes from front to back and allow us to detect disease earlier, plan surgery more accurately, and track changes over time.
- As part of your evaluation, we will be performing the following non-invasive imaging:
    - Optomap Ultra-Widefield Retinal Imaging
        - Provides a 200° view of the retina to detect early retinal disease, circulation changes, and systemic health markers.
    - Advanced Corneal Topography / Tomography
        - Analyzes the front and back surfaces of the cornea to detect early keratoconus, dryness patterns, and assess candidacy for LASIK, ICL, or lens surgery.
    - OCT Macula Scan
        - High-resolution imaging of the central retina to detect early macular degeneration, epiretinal membranes, diabetic changes, or vitreomacular traction.
    - OCT Optic Nerve / RNFL / GCC Scan
        - Evaluates the nerve fiber layers to detect early glaucoma and optic nerve pathology before symptoms arise.

- These tests are recommended annually and required for all refractive and premium cataract evaluations.
- You may accept or decline these tests:
- ⬜ YES – I elect the Advanced Visionary Eye Screening and understand the fee of $99 is my responsibility.
- ⬜ NO – I decline the Advanced Visionary Eye Screening, which may limit the physician's ability to fully evaluate my eye health and surgical candidacy.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

VISIONARY EYE

HIPAA RELEASE FORM

In accordance with HIPAA laws we need your authorization to speak with anyone by you with regards to your personal medical information. In the area below, please complete the information to let **Visionary Eye Surgery, PLLC** know how you would like us to handle your private medical information.

I, _____, give **Visionary Eye Surgery, PLLC** permission to speak with the following people regarding my personal medical information.

_____

Name Relationship

□ Please check this box if you do not wish us to speak with anyone but you with regards to your personal medical information.

_____

Patient Signature Date

VISIONARY EYE

Patient Name:_____ Date Completed:_____

Visionary Eye Credit Card on File Policy:

As healthcare continues to evolve, we recognize the importance of ensuring timely payments for services rendered. With high-deductible health plans becoming more common, patients are increasingly responsible for their balances. To streamline this process, we have implemented a **Credit Card on File Policy.**

How It Works:

- **At the time of registration,** we will request your credit card information.
- Your credit card numbers will be **encrypted and secretly stored off-site;** no card details will be kept at our practice.
- After receiving your Explanation of Benefits (EOB) from your insurance company, we allow **30 days** for your to pay any outstanding balance.
- If the balance remains unpaid, your credit card will be charged for the amount due.

Benefits for You:

- **Convenience:** Pay balances and co-pays conveniently.
- **Automatic Payments:** Use your preferred credit card for automatic payments.
- **No checks:** Avoid writing checks or mailing payments.
- **Email Notifications:** Receive receipts and notifications via email.

Please note that this policy **does not affect your rights** regarding credit care usage. You can still dispute charges or question insurance determinations.

Your credit card on file may be used for:

- Visit payments not collected initially.
- No-show or late cancellation charges.
- Insurance discrepancies.
- Outstanding balances overdue by more than 31 days.

Credit Card Type (check one): ☐**Visa** ☐**Master Card** ☐**Discover** ☐**Amex**

Credit Card Information:

- Card Number:
- Security Code:
- Expiration Date:
- Name appears on the credit card:
- Billing Address:

Patient Authorization: I authorize **Visionary Eye** to charge the credit card above as per the terms of this policy. This authorization remains in effect until revoked in writing. The credit card number will be redacted before scanning this form into the Electronic Medical Record. Feel free to reach out to our office if you have any questions about this payment method.

_____ Decline

Patient Signature: _____ Date: _____

VISIONARY EYE

Patient Name:_____ Date Completed:_____

Educational & Media Release Form:

_____I grant permission to VISIONARY EYE and its agents or employees to observe and use photographs and/or video taken of me on the date listed below for use in promotional and educational training, materials such as brochures, newsletters, advertisements, and magazines, and to use such photographs/video in electronic versions of the same publications or on VISIONARY EYE websites or other electronic forms of media, and to offer them for use or distribution in other publications, electronic or otherwise, without notifying me. Furthermore, I authorize the use of my name, likeness, and voice for all program promotion, institutional promotion, and any other purposes in connection with the program deemed appropriate and necessary by VISIONARY EYE.

_____I hereby waive any right to inspect or approve the finished photographs/video or printed or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photographs/video/website.

_____I hereby agree to release, defend, and hold harmless VISIONARY EYE and its agents or employees, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper, via electronic media, or on websites, from and against any claims, damages, or liability arising from or related to the use of the photographs/video, including but not limited to any misuse, distortion, blurring, alteration, optical illusion, or use in composite form, either intentionally or otherwise, that may occur or be produced in taking, processing, reduction, or production of the finished product, its publication, or distribution.

_____The statements attributed to me in any testimonial I make available reflect my actual experience with the Licensed Parties and my candid opinions about the Licensed Parties and/or their products and services. I understand that I have the right to rescind this Consent and Release by delivering written notice to the Office Administrator of VISIONARY EYE; provided however that this will not enforce any requirement upon the Licensed Parties to recall or destroy any materials already used, published, or disclosed.

_____I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

By signing below, I understand and agree with the above initial statements.

_____ Decline

Patient Signature: _____ Date: _____

VISIONARY EYE

Consent to Treatment Form

Patient Name: _____ Date of Birth: _____

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1. Purpose of Consent
I voluntarily consent to receive medical and/or surgical care, diagnostic tests, and treatments provided by the physicians, optometrists, technicians, and staff at Visionary Eye. This includes routine eye examinations, diagnostic imaging, dilation, refraction, and minor office-based procedures as deemed necessary for my care.

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2. Risks and Benefits
I understand that:

- No treatment or procedure is without risk.
- Risk may include, but are not limited to: temporary discomfort, changes in vision, dilation side effects (such as light sensitivity or blurred near vision), allergic reactions to medications, and – in the case of procedures or surgeries– rare but serious complications.
- The risks, benefits, and alternatives to any procedure will be explained to me before it is performed.

Patient Initials: _____

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3. Medication and Dilation
I understand that certain eye examinations may require dilation of my pupils and/or the use of diagnostic medications. These may temporarily impair my ability to drive, work, or read. I will take appropriate precautions as advised by my provider.
Patient Initials: _____

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4. Laboratory, Diagnostic, and Referrals
I authorize the release of necessary health information to other healthcare providers, laboratories, or insurance companies for the purpose of my diagnosis, treatment, and /or payment.
Patient Initials: _____

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5. Consent to Photography/Imaging
I consent to diagnostic imaging and photography of my eyes and related structures for the purpose of diagnosis, treatment, and documentation of my medical record. These images will not be shared for educational or promotional use without my separate written authorization.
Patient Initials: _____

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6. Financial Responsibility
I understand that I am responsible for payment of services rendered, including any amounts not covered by insurance.
Patient Initials: _____

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7. Right to Refuse or Withdraw Consent
I understand that I have the right to refuse treatment or withdraw my consent at any time, recognizing that this may affect my care.
Patient Initials: _____

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8. Acknowledgement
I acknowledge that I has the opportunity to ask questions and that all questions were answered to my satisfaction.

Patient/Legal Representative Name (Print): _____
Relationship (if not patient): _____
Signature: _____ Date: _____
Provider/Witness: _____ Date: _____

VISIONARY EYE

Patient Name:_____ Date Completed:_____

What is the reason for your visit today? _____

_____

History of eye surgery? (check one) ☐**Yes** ☐**No**

	Eye	Date		Eye	Date
☐Cataract Surgery			☐Macular Degeneration		
☐Injury/Trauma			☐Glaucoma		
☐Glaucoma Surgery			☐Cataracts		
☐RK/PRK/LASIK Surgery			☐Dry Eyes		
☐Retinal Surgery			☐Strabismus Surgery		

☐Other_____

List of current eye drops being used: _____

Do you wear glasses? ☐Yes ☐No If **Yes,** ☐Single Vision ☐Bifocal ☐Trifocal ☐Progressive ☐Readers

Do you wear contact lenses? ☐Yes ☐No If **Yes,** are they soft or hard lenses: _____

When was the last time you wore them? _____ ☐Single Vision ☐Monivision ☐Multifocal ☐N/A

Family history of eye disease? ☐Yes ☐No If **Yes,** please explain _____

History of major health problems? ☐Diabetes ☐High Blood Pressure ☐High Colesterol ☐Heart Disease ☐Stroke ☐Kidney Disease ☐Dementia ☐Cancer _____

Other: _____

List of current medications: _____

_____

_____

Drug Allergies: _____ ☐ **None**

Past Surgical History: ☐Neck ☐Back ☐Head

Other surgeries in the last 10 years: _____

Primary Care Provider: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

Other Specialist:_____ Phone #: _____

Preferred Pharmacy:_____Street or Intersection: _____

City:_____ Phone #: _____

VISIONARY EYE

Patient Name:_____ Date Completed:_____

Review of Systems

☒ *Please **X** if applicable*

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Negative

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight loss
- ☐ Negative

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Negative

Genitourinary
- ☐ Genital Discharge
- ☐ Genital lesions
- ☐ Painful urination
- ☐ Urgency
- ☐ Negative

HEENT
- ☐ Dizziness
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Sorethroat
- ☐ Negative

Hematologic
- ☐ Bleeding
- ☐ Bruising
- ☐ Tender Nodes
- ☐ Negative

Metabolic
- ☐ Cold intolerance
- ☐ Excess hunger
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Hear intolerance
- ☐ Negative

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Stiffness
- ☐ Swelling
- ☐ Negative

Neurological
- ☐ Balance problem
- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Negative

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomia
- ☐ Irritability
- ☐ Nervousness
- ☐ Negative

Respiratory
- ☐ Cough
- ☐ Trouble breathing
- ☐ Wheezing
- ☐ Negative

Skin
- ☐ Hair loss
- ☐ Rash
- ☐ Skin lesions
- ☐ Negative

Social History

☒ *Please **X** if applicable*

Smoking

Frequency
- ☐ 1- Current Every Smoker
- ☐ 2- Current Some Day Smoker
- ☐ 3- Former Smoker
- ☐ 4- Never Smoked
- ☐ 5- Smoker, Status Unknown
- ☐ 6- Unknown if Ever Smoked

Type of Tobacco
- ☐ Cigarettes
- ☐ Cigar
- ☐ Pipe
- ☐ Electronic Cigarettes

Alcohol

Frequency
- ☐ Never
- ☐ Rarely
- ☐ Occacional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Alcohol
- ☐ Beer
- ☐ Liquor
- ☐ Wine

Recreational Drugs

Frequency
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Drug
- ☐ Amphetamines
- ☐ Cocaine
- ☐ Intravenous drugs
- ☐ Marijuana

Occupation
- ☐ Business
- ☐ Manual labor
- ☐ Office work
- ☐ Retired
- ☐ Student
- ☐ Teacher
- ☐ Other

Hobbies
- ☐ Computers
- ☐ Music
- ☐ Sewing
- ☐ Sports
- ☐ Travel
- ☐ Other