VISIONARY
EYE CARE

Welcome to Visionary Eye Care

Anchored in Care. Focused on Clarity.

Dear Patient,

Thank you for choosing **Visionary Eye Care** for your eye health needs. We are honored to be part of your care and look forward to providing you with a thorough, comfortable, and personalized experience.

To help us prepare for your visit and ensure your appointment runs smoothly, please complete the enclosed **New Patient Paperwork**. Bringing these forms with you—along with a valid photo ID, your insurance cards, and any current glasses or contact lenses—allows us to verify your information and provide you with efficient, high-quality care.

At Visionary Eye Care, our mission is to illuminate the path to clearer, healthier vision through compassion, innovation, and an unwavering commitment to excellence. Every detail of our practice is designed with your comfort, clarity, and confidence in mind.

If you have any questions while completing your paperwork or need assistance before your appointment, please contact our office at **(256) 907-2045**. We are always happy to help.

We look forward to caring for you and welcoming you into the Visionary Eye Care family.

Warmly,
Dr. Samantha Myers & The Visionary Eye Care Team

VISIONARY EYE CARE

Samantha Myers, O.D.
1312 SR-77
Southside, AL 35907
Office: (256)-907-2045
Fax: (256)-907-2313

Patient Information

Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ SSN: _____-_____-_____ Sex: M F

Email: _____

Legal Guardian or Spouse: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Primary Physician: _____ Physician Phone: _____

Insurance Information

PRIMARY MEDICAL INSURANCE

Subscriber Name:
_____

Subscriber SSN:
_____

Subscriber DOB:
_____

Contract Number:
_____

VISION INSURANCE

Subscriber Name:
_____

Subscriber SSN:
_____

Subscriber DOB:
_____

Contract Number:
_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners. **I understand that I am financially responsible for all charges, regardless of insurance payment. I authorize the doctor to release any information necessary to process claims and permit the use of my signature on all insurance submissions. I understand that certain routine services or materials deemed necessary for my care may not be covered by my insurance, and I agree to pay these charges in full.** If my account becomes delinquent and requires collection services or legal action, I agree to pay all reasonable collection fees, attorney fees, and court costs. I have read and agree to the policies above, as indicated by my signature.

_____ _____

Patient or Responsible Party Signature Date

CURRENT AND PAST MEDICAL CONDITIONS (check all that apply)

☐	Anxiety / Depression	☐	Diabetes (Type 1 / Type 2)	☐	Leukemia
☐	Arthritis	☐	Hypertension	☐	Radiation Treatment
☐	Asthma	☐	Epilepsy	☐	Eczema / Rosacea
☐	Atrial Fibrillation	☐	Hearing Loss	☐	**Pregnant/Nursing**
☐	Stroke	☐	HIV Infection	☐	Other:_____
☐	Chronic Obstructive Lung Disease (COPD)	☐	Hepatitis Infection		
☐	Heart Attack / Vascular Disease	☐	Thyroid Conditions		
☐	Migraine / Headaches	☐	High Cholesterol		

OCULAR HISTORY (check all that apply)

☐	None	☐	Keratoconus
☐	Cataracts	☐	Ocular Hypertension
☐	Corneal Dystrophies	☐	Ophthalmic Migraine
☐	Diabetic Retinopathy	☐	Retinal Tear / Detachment
☐	Dry Eyes	☐	Strabismus / Eye Turn
☐	Glaucoma	☐	Vitreous Floaters
☐	Macular Degeneration – Wet / Dry	☐	Wears Contacts (Soft / RGP)
☐	Other: _____	☐	Wears Glasses

Past Ocular Surgeries:

_____

Current Medications:

_____

_____

_____

Medication Allergies:

_____

_____

_____

Social History: Do you drink alcohol? YES/NO Do you smoke tobacco? YES/NO

FAMILY HISTORY (check all that apply)

	CONDITION:	RELATIONSHIP:
☐	Cataracts	
☐	Corneal Problems	
☐	Glaucoma	
☐	Lazy Eye	
☐	Macular Degeneration – Wet/Dry	
☐	Blindness	
☐	Retinal Problems	
☐	Diabetes	
☐	Heart Disease	

Financial Policy:

We provide the best possible care and service. Understanding of our financial policies is an essential element of care and treatment. To assist, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

Insurance Coverage:

You are responsible for providing accurate insurance information at the time of service and for understanding your plan's coverage, including whether your visit is fully, partially, or not covered. It is also your responsibility to know if your plan requires a referral from your primary care physician. Some patients have additional vision benefits through a different carrier. If you do not inform us of this secondary coverage at the time of service, you will be responsible for all charges. We are happy to provide an itemized receipt for you to submit to your insurer.
For the most accurate benefit information, please verify details directly with your insurance plan. If you do not confirm your coverage and your insurer denies full or partial payment, you will be financially responsible for all services rendered.
Initial _____

Routine and Medical Eye Exams:

Our office participates with certain vision plans for routine eye exams, which are defined as regular check-ups for patients without eye problems. If the doctor identifies a medical condition (such as dry eye, floaters, or similar issues), the visit may be billed as a medical eye exam and submitted to your medical insurance. If your plan requires a referral, you must obtain one prior to your appointment. Insurance regulations often prevent routine and medical exams from being performed on the same day. If you prefer to proceed with only the routine portion during your visit, you may be asked to return on a separate day for the medical evaluation.
Please note that some insurance plans consider routine eye exams to be non-covered services.
Vision Plan Patients: I have read and understand the above routine eye care policy. Initial _____

Spectacle and Contact Lens Exams:

Exams for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We require this fee to be paid at the same time of service. Initial _____

Amounts Due from the Patient:

We accept cash, personal checks, CareCredit, and Visa or MasterCard. All insurance co-payments are due at the time of service. If we are not in network with your insurance plan, full payment is required at the time of your visit. We will provide an itemized statement you may submit to your insurance for reimbursement. When using insurance, we make every effort to collect accurate fees based on your plan. However, if your insurer later determines that additional fees apply, these must be paid in full before glasses and/or contact lenses can be dispensed. Initial _____

Acknowledgement of Receipt

I have reviewed the HIPAA Notice of Privacy Practices, have been provided with an opportunity to discuss my right to privacy, and know that upon request I will be given a copy of the notice. Initial _____

Amounts Determined "Not Covered"

If your health plan determines that a service is "not covered," you will be responsible for the full charge. A common example is **refraction**; the procedure used to determine changes in your eyeglass or contact lens prescription. Many insurance plans, including Medicare, do not cover refraction. If you choose to have your prescription checked, you may be personally responsible for this fee. If you do not want a refraction performed, please notify our staff in advance. Please also note that some insurance plans classify routine eye exams as non-covered services. Initial _____

I have read and understand the financial policies of Visionary Eye Care and understand that Visionary Eye Care reserves the right to change any and all fees at any time.

_____ _____

Signature of Patient (or responsible party if patient is a minor) Date

Authorization to Send and Receive Medical Information by Email/Text

Visionary Eye Care ("us" or "we" or "our") sends information by email and/or text ("messages") to the patient ("you" or "your").

RISKS: Transmitting messages has several risks you should consider, including:

Messages can be forwarded, circulated, intercepted, received by many unintended recipients, easily misaddressed by the sender, used to introduce viruses, and not all message service providers support end-to-end encryption.

Messages are easy to falsify, backup copies of messages may exist even after they've been deleted, and employers and online services have a right to archive and inspect messages transmitted through their systems.

CONDITIONS: Because of the Risks outlined above we cannot guarantee the security and confidentiality of email/text communication, and we will not be liable for improper use and/or disclosure of confidential information that is not caused by our intentional misconduct. Thus, you must consent to the use of email/text and agree with the following conditions:

1. All messages to or from you concerning diagnosis or treatment will be saved as part of the medical record and other authorized individuals will have access to those messages. We may forward messages internally to our staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling.

2. Although we will endeavor to read and respond promptly to a message from you, we cannot guarantee that any message will be read and responded to within any period. Therefore, you should not use messages for medical emergencies or other time-sensitive matters.

3. If your message requires or invites a response, and you have not received a response within a reasonable time, it's your responsibility to follow up with us to determine whether the intended recipient received the message and when the recipient will respond.

4. You should not use messages for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. You are responsible for informing us if there are any other types of information you don't want to be sent by email/text.

5. You are responsible for protecting your password or other means of access to email/text. We are not liable for breaches of confidentiality caused by you or any third party.

INSTRUCTIONS: To communicate by email/text, you shall:

Inform us of changes in your email address or text number, put your name in the body of the message, include the category of the communication in the email's subject line or body of a message for routing purposes (e.g., billing question), review the message to make sure it is clear and that all relevant information is provided before sending, take precautions to preserve the confidentiality of messages, and withdraw consent to email/text only by email or written communication.

Contact our privacy official at 256-907-2045 with any unanswered questions before communicating with us.

PATIENT ACKNOWLEDGMENT AND AGREEMENT: I acknowledge that I have read and fully understand the risks associated with communication by email and text, and consent to the conditions and agree to the instructions outlined above.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Phone number for text messages

_____

Email address authorized for sending medical records