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Visionary Optics Sight*Support* Program

APPLICATION

We believe the gift of sight is a gift like no other. Visionary Optics is dedicated to providing our services (lens designs, consultation expertise and customer service) to ensure your patients have the best opportunity for success. Please complete the below form if you have a patient who would be an excellent candidate for our Sight*Support* Program. Through this program, you will receive a complimentary scleral lens fit for your patient while working with our expert Consultation Team to ensure the most optimal possible fit.

What are we requesting from you?
We ask that, in return, you document the journey with pictures of the lens fitting process – slit lamp, lens on eye, and a picture of the patient with you or staff members. Once your patient's fit has been finalized, we request the following two forms be completed: the **Sight*Support* – OD Testimonial** form should be completed by you (the doctor) & the **Sight*Support* – Pt Testimonial** form should be completed by your patient. By enrolling your patient into the Sight*Support* Program, you are agreeing that the material submitted can be used for Visionary Optics' marketing. Please ensure that your patient understands this.

How does the Billing aspect work?
You will be billed for the patient's lenses. We will then credit your account for the full amount of the fit (Shipping Charges still apply) upon receipt of both the **VO Sight*Support* – OD Testimonial** & **VO Sight*Support* – Pt Testimonial** forms.

Please send this completed application to service@visionary-optics.com (or fax to 540.635.8846).

Account # _____ Doctor's Name_____

Date of Application _____ Patient's Full Name_____

Brief description of why this patient would benefit from the Visionary Optics Sight*Support* Program.