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CONTACT LENS FEE

Contact Lens Fitting and Evaluation (if applicable):

Contact lenses are an alternative to glasses which often provide both functional and cosmetic advantages. They are, however, medical devices which can potentially cause eye problems if they are poorly fit, or cared for improperly. As a contact lens wearer, we provide your ongoing care to insure the best possible visual results, safety and patient satisfaction.

Contact lens fittings and subsequent regular evaluations are additional services and are not included in the cost of your eye exam. Medical insurance does not cover these contact lens related services, but some vision plans do pay for some contact lens fees. All contact lens related follow up appointments within 90 days are included, as are the trial lenses that are dispensed.

Payment for contact lens services and contact lens orders is due at the time services are rendered or when the order is placed, whether in person or by phone.

CONTACT LENS PRESCRIPTIONS ARE VALID FOR ONE YEAR BY STATE LAW

Standard Annual Contact Lens Fees:

Annual contact lens fee (Established): \$50

Refit Fee (Changing brands or types of lenses): \$60

New fit / Teaching fee - Standard contacts: \$100

New fit / Teaching fee - Toric Contacts: \$120

New fit / Teaching fee - Multifocal Contacts: \$130

I acknowledge that I am receiving a copy of my contact lens prescription in accordance with the Federal Trade Commission (FTC) Contact Lens Rule. I understand that contact lens fittings and evaluation services are separate from a routine eye examination and may be considered non-covered services by my insurance plan. I accept full financial responsibility for all contact lens related fees and understand payment is due at the time of service. I further understand that any copayment, deductible, coinsurance, or other patient responsibility required by my insurance plan is separate from and not included in the contact lens fitting fee.

Please indicate how you would like to receive your contact lens prescription:

☐ Printed Copy ☐ Electronic Copy ☐ Declined Copy

Patient Signature: _____ **Date:** _____