DISEASES AND SURGERY OF THE EYE

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Refraction and Contact Lens Fees

Refraction: $65 ($50 if paid at time of service):

One of the most important parts of your eye exam today is the refraction. A refraction is how we test your vision; this is where your doctor determines what, if any, prescriptions are needed to correct or assist your vision. While a refraction is important for a comprehensive eye exam, this charge is only covered by SOME medical insurances as most do not consider this testing as medically necessary.

For vision insurance plans you may be charged additional fees for medical testing.

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.

CONTACT LENS PRESCRIPTIONS ARE VALID FOR ONE YEAR BY STATE LAW.

Payment is required at time of placing your contact lens order in person or over the phone.

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 I am receiving a copy of my Contact Lens Prescription and/or Glasses Prescription if needed. I have read the above information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I also understand that any copayment, coinsurance or deductible I may have are separate from and are not included in the refraction fee.

Patient Signature:_____ **Date:** _____