Contact Lens Evaluation for Contact Lens Wearers

As a contact lens patient to our practice, it is necessary for the doctor to perform additional testing to assess the fit of your present contact lenses. Contact lenses are FDA-approved medical devices and must be checked yearly by the doctor. Prescriptions and contact lenses cannot be dispensed by your doctor if your prescription and fit assessment is older than one year. This part of the exam is not routinely covered by most insurance. If you need further clarification, the doctor will discuss the professional contact lens service fee to be charged prior to the service being rendered.

The professional service fee for this additional part of the exam is $39.00. If your present lenses that have been fit and prescribed elsewhere, are determined to now have a less than acceptable fit or are not safe for the health of your cornea, a contact lens re-fit will be advised.

The professional service fee for any recommended re-fit may vary according to the extent of changes needed and the number of follow up visits required to ensure a successful and healthy contact lens fit going forward. For both new and existing patients, re-fitting fees would apply if you change to multi-focal contact lenses or toric contact lenses, and/or the discontinuation of your existing contacts necessitates changing to a new lens style or brand.

The contact lens evaluation $39 fee is a yearly fee for all patients to Eye Physicians and Surgeons.
Payment for the contact lens evaluation service fee is expected at the time of the examination and is non-refundable.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

___**YES**, I would like a contact lens evaluation today in order to update my contact lens prescription and have the ability to purchase contacts for the next 12 months. I understand that the evaluation fee must be paid at the time of service.
___**NO**, I do not want a contact lens evaluation today and understand that I will not be able to purchase contacts without an updated lens prescription.

_____ ____ /_____ /_____

Patient / Parent or Guardian **Date**