

CONTACT LENS FEE POLICY

It is our policy that all patients that are currently wearing contact lenses be seen every year for a contact lens examination. **If you are a new patient to our office it is helpful if you can provide the prescription for the lenses that you are currently wearing.** If there are no problems or changes in lenses, the cost of this service will range between \$50 and \$150. This charge is in addition to the cost of the comprehensive exam. The fitting fee, which includes follow-up care within the first 60 days, is determined by the type of lenses prescribed, the difficulty of the fit, and whether or not the patient is a first time contact lens wearer. **THIS FEE IS NON REFUNDABLE.** We can discuss lens options and prices in more detail once the initial examination is completed.

The fitting fee includes:

- The contact lens fitting.
- Follow-up visits up to 60 days.
- Lens changes if necessary, though the patient is responsible for any difference in cost of the contact lenses.

The fitting fee does not include:

- Contact lenses (Costs will vary depending on type of lens prescribed).
- The comprehensive eye exam.
- Medical visits not directly related to contact lens wear.
- Contact lens checks after 60 days.

PAYMENT

Fees for the comprehensive exam, contact lens fitting, or annual contact lens checks are **due at the time of service.** All RGP lenses are ordered with a warranty to guarantee they are returnable within 60 days. Replacement RGP contact lenses will only be dispensed when original lenses are returned to our office. We accept cash, checks, VISA and MASTERCARD. After the initial fit, we will gladly order contact lenses over the phone with a credit card as long as the prescription is valid.

REFUNDS

There will be no refund on custom lenses, opened boxes of lenses, or colored lenses because of dissatisfaction with the color.

If, however, the doctor decides to discontinue the patient's contact lens use, a full refund of the unopened contact lenses will be given. There will be **NO** refund of the exam, fitting, or annual contact lens check fees.

I have read and understand the Contact Lens Policy. All of my questions have been answered and I have received copies of the above information. I understand that my compliance with the Contact Lens Care Guide is of the utmost importance in the health of my eye.

Patient/Guardian Signature

Date