



CONTACT LENS POLICY AND FEES

Contact lenses are an FDA-regulated medical device and by law require evaluation before a final prescription is written. Full payment of the contact lens evaluation fee is due at the time of the evaluation. Lenses are to be paid in full when the order is placed. Contact lenses are a custom-fit product, and no refunds or exchanges are given once the contact lens prescription is finalized.

If either you or your doctor decides to stop the evaluation of the contact lenses, we cannot refund our professional fees due to the time invested in your evaluation process. _____ (initials)

Professional Fees:

- ☐ Soft Contact Lens **Renewal** Evaluation: \$100 _____ (initials)
- ☐ Soft Contact **New** Evaluation: \$145 _____ (initials)
- ☐ Rigid Gas Permeable & Scleral Contact Lens **New** Evaluation: \$500 _____ (initials)
- ☐ Rigid Gas Permeable & Scleral Contact Lens **Renewal** Evaluation: \$300 _____ (initials)

Contact Lens Evaluation:

- Includes training on the insertion and removal, as well as care instructions.
- Allows up to 2 follow up visits in a 45 day window to ensure a healthy contact lens fit. After 2 visits, if you have not been finalized in your contact lens prescription, you may be recharged the contact lens evaluation fee. Insurance does not cover a second evaluation fee.
- Your contact lens prescription will be provided to you upon completion of your contact lens evaluation.

I consent to the contact lens evaluation policy and fees:

Patient or Guardian Signature: _____ Date: _____

Current Email: _____ Phone Number: _____

Decline Evaluation: _____ **Date:** _____
(by signing here, I understand that I will not receive a new or updated contact lens prescription)

To Order Contact Lenses

Contact lenses may be ordered at any time after the evaluation is complete. At your request, we can order your contacts for you, collect payment and direct ship to your home. Please call (509) 468-2020 to order.

To Be Completed by Staff:

Patient Left Wearing (Check one): Dailies: _____ Monthly _____ RGB _____ Scleral: _____

Optician: _____ Date: _____ Date Current Contact Lens Rx Expires: _____