CONTACT LENS FEES & POLICIES

Contact lens fitting is not part of the standard annual eye exam and is *not covered* by most insurance plans.

The fee charged will be determined by the category the contact lens wearer falls under.

New Contact Lens Patient: Patients who have never worn contact lenses before.

Replacement Wearers: Patients who have a valid contact lens prescription, has little to no change to their prescription and remain in the same brand and type of contact lens.

Refit Patients: Patients who have a valid contact lens prescription who have a significant change to their prescription, changes contact lens type (ex. Spherical to Toric) or have had contact lenses in the past and would like to be refitted for contact lenses.

Custom/Specialty: Patients who are in gas permeable, hybrid or any type of specialty contact lens. The doctor will determine and let you know prior to fitting.

Replacement Wearers	**$30.00**
Refit Patients	**Spherical Contacts $50.00**
	Toric Contacts $60.00
	Multifocal Contacts $80.00
Custom/Specialty	**$100.00 & Up**

New Contact Lens Patients Insertion/Removal Training	**Spherical Contacts $120.00**
	Toric Contacts $130.00
	Multifocal Contacts $150.00

Contact Lens Fitting Includes the following:
1) **Contact Lens Fitting Exam**
2) **Follow up visits up to 45 days**
3) **Trial Lenses**
4) **Lens Care Kit**
5) **A copy of your Contact Lens Prescription**

Your contact lens prescription will be valid for two (2) years once your final prescription has been determined. A fitting process will be required for any contact lens prescription issued.

Contact Lens Disclosure:

As with any drug or device, the use of daily wear or extended wear contact lens is not without risk. A small percentage of individuals develop potentially serious complications that can lead to permanent eye damage. If you have any unexplained pain, redness, watery eyes, discharge, cloudy, foggy or decrease in vision or increased sensitivity to light, remove your contact lenses and seek care. Arrangements should be made to see your eye care professional before wearing your contact lenses again.

By my signature, I acknowledge that I have read this document and will comply with the recommended care.

Patient or Guardian _____ **Date** _____