EYE FLORIDA Contact Lens (CL) Evaluation Fee & Policy

Thank you for considering a contact lens evaluation with the doctors of **EYE FLORIDA.** We would like you to understand what is involved with a contact lens evaluation and if you have any questions, please do not hesitate to ask. Please inform the front desk staff if you have a **VISION INSURANCE PLANS WITH CONTACT LENS BENEFITS.** Benefits will need to be verified on date of visit before a contact lens exam can be perform by the Provider, otherwise you will be charged the **SELF PAY CONTACT LENS FEE RATE** (SEE BELOW).

TYPE OF CL FITTING EXAM:

1. **FOR NEW CONTACT LENS FITTING**: If you have never worn contact lens and are interested in CL fitting, measurement of your cornea (autorefractor, corneal topography) and a prescription of your eye (refraction) will be determined at your first eye exam visit including examination of your ocular health and suitability for contact lens wear. If we have your contact lens prescription in stock, we will do a fitting and will dispense these contact lens as a trial pair. A staff member will review insertion and removal techniques and proper CL cleaning techniques before the trial pair will be dispensed. You will be asked to schedule a follow up in **1-2 weeks** to recheck CL fitting, ocular health, and finalize your CL prescription. **FEE $150**
2. **FOR YEARLY CONTACT LENS FITTING (FOR ESTABLISHED PATIENT TO EYE FLORIDA AND CURRENT CONTACT LENS WEARER)**: In order to do yearly contact lens exam, you will need to bring your contact lenses in their original cases at the time of visit. If you do not have your contact lenses and if we do not have your CL prescription in stock, a trial pair will be ordered. At the time of your CL fitting, your final CL prescription will be available. No follow up visit will be required for CL Refit. **Fee $110**
3. **CONTACT LENS FITTING LESS THAN 1 YEAR:** If you had a contact lens fitting that was less than one year and you need a REFIT/RECHECK of CL prescription/Update of CL prescription, a CL REFIT with trial CL will be performed by the Provider. **Fee $69**

Notice: Your evaluation/fitting fee covers your trial lenses and up **to 1 month of follow-up care**. Follow-up care is vital to determine the fit of the lens and to protect the health of the eye. If you elect to forego the follow-up care and return beyond the initial 30 (thirty) day period, you will be charged a **refitting fee of $69.00**. We do urge you to protect your vision and return for the follow-up care. Trial lenses are not for permanent use. You must have follow-up care to be able to buy contact lenses and get your **final contact lens prescription**. The prices of contact lenses will vary depending on the type of contacts that your doctor recommends and your prescription.

The fitting fee and any cost relating to contact lenses must be paid in full before you wear them out of the office. Changes in your contacts can be made within the first **30 (thirty) days**. If within the 30 day-up period, you feel that contact lenses that you have purchased are not for you, then we will **credit your account** for the portion of the contact lenses that is refundable**. Lenses are returnable if they are in the original bottles or unopened boxes within one month of purchase.** You may use this credit towards glasses or for a purchase by another family member.

THE EVALUATION/FITTING FEE IS NOT REFUNDABLE.

Fairness to Contact Lens Consumers Act: This act went into effect February 4, 2004. As stated by this act, you will be given a copy of your contact lens prescription once the prescription is finalized with the examining doctor. Receiving a trial lens IS NOT a finalized prescription. A finalized prescription is determined at the follow up appointment after you have been wearing the trial lenses. The doctor/assigned certified staff will approve the fit and vision with the contacts. At this point, you may receive a copy of your prescription. I have read and understand the above information and agree to the terms set forth in this contract and have had all my questions answered.

Patient/Guardian Name: _____DOB: _____Signature: _____Date: _____

STAFF/PROVIDER REQUIRED TO FILL OUT ALL INFO BELOW: Staff/PROIVDER Name: _____Date: _____

VISION INSURANCE PLAN WITH CL BENEFITS: YES / NO . IF YES _____CONTACT LENS SUPPLY BENEIFTS: YES / NO. IF YES _____

Fee Due: _____***CL TRIAL ORDERED***: _____ **CL FITTING DATE**: _____ **CL F/U DATE**: _____