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Annual Contact Lens Agreement

At Family Vision Care, we carry the latest in contact lens technology and specialize in difficult-to-fit patients. This includes lenses for astigmatism (toric lenses), multifocal contact lenses, lenses for corneal disease (such as keratoconus), and lenses for post-surgical corneas. We are dedicated to the health of your eyes, and an enjoyable contact lens experience!

A **Contact Lens Evaluation Fee** is necessary to determine your contact lens prescription (or to renew your current contact lens prescription) and is in addition to the comprehensive exam fee. This evaluation will include precise measurements, analysis of your visual needs, and recommendations tailored specifically for you. It may also include the use of diagnostic lenses by our doctor or technicians to ensure a proper fit and good ocular health.

For those patients who are new to wearing contact lenses, a **$25 training fee** will be applied to your visit. This is for a 30 minute class on how to properly insert and remove your contact lenses, as well as how to take good care of them. If you are unable to successfully finish training in 30 minutes and need to return, each additional training class will also be $25.

The **Contact Lens Evaluation Fee** will vary depending on the complexity of your contact lenses. This fee will cover the initial evaluation and any follow-ups during the first **SIXTY DAYS**. After sixty days, follow-ups will be charged at $53 per visit. Your evaluation may fall into one of the following categories:

Established Soft Lens evaluation, no major changes	$65
Advanced Soft Lens Evaluation (soft multifocal/monovision, custom lenses)	$125+
Rigid Gas Permeable (RGP) lenses, established wearer	$100
New RGP/scleral lens wearer	$200+
Medical Evaluation (keratoconus, post-surgical)	$900+
Ortho-keratology (Gentle Vision Shaping System)	$1500 (year one), $550/yr year two and beyond

Contact lens prescriptions are valid for ONE YEAR and must be re-evaluated every year to ensure a proper fit, acceptable vision, and good ocular health.

Patient (or parent/guardian) signature: _____

Date: _____