VISUALLY SOUND
OPTOMETRY

CONTACT LENS FITTING AND EVALUATION AGREEMENT

The contact lens evaluation and fitting is an additional fee NOT included in your comprehensive examination unless you qualify as medically necessary per your vision insurance parameters. The price for this extra service depends on the type of contact lens and complexity of the contact lens fit decided by the doctor. The fee includes the initial visit, contact lens training, and all follow-ups for a 90-day period. After this 90-day period, additional fees may apply.

Policies:

- Charges for fitting fees are due in full at the time of the fitting/evaluation.
- All follow-ups extending past the 90 days are subject to normal office visit rates.
- We will be happy to confirm your insurance benefits in relation to the contact lenses and fitting costs. Any uncovered expenses become the patient's responsibility.
- If you do not finalize your contact lens prescription within the office-fitting period, your insurance provider will automatically be billed for the allowed services, which may affect other aspects of your coverage. This includes covered contact lens plans.
- You are responsible for keeping all follow-up appointments to finalize your prescription.
- Your prescription will not be released until the doctor has finalized it.
- All fees are nonrefundable.
- All prescriptions are valid for one year.
- If you purchase a supply of contacts then we will be happy to replace any torn, damaged, or defective lenses at no cost to you and at any point during the year.

Fee Schedule is provided below. This does not include routine eye exam, copays, or other fees.

CONTACT LEND FITTING FEE – NEW	**CONTACT LENS FITTING FEE - ESTABLISHED**
Level 1 (Soft Spherical): $80	Level 1 (Soft Spherical) $60
Level 2 (Soft Toric, Multifocal, RPG): $100	Level 2 (Soft Toric, Multifocal, RPG): $80
Level 3 (KC, Specialty RPG): $150	Level 3 (KC, Specialty RPG): $120

I UNDERSTAND AND WILL COMPLY WITH THE ABOVE POLICIES AND FEE SCHEDULE.

Patient or Guardian Name (print): _____

Patient or Guardian Signature: _____ **Date:** _____