Eye Physicians
Medical/Surgical Center, Inc.
A Medical Group

CONTACT LENS CHARGES

THE CONTACT LENS FITTING FEE IS IN ADDITION TO YOUR EYE EXAMINATION FEES.

*****Please note that your insurance may or may not cover the cost of the contact lenses services.**

Contact Lens Exam

Contact lenses must be appropriately fit to ensure optimal visual performance. The contact lens fitting fee includes:

- Slit lamp examination and measurement of the cornea
- Selection and use of trial contact lenses
- Instructions on the handling, insertion, removal, care and storage of contact lenses.
- Follow-up visits for a period of 90-days from the date of the initial contact lens fit.

Contact Lens Materials

You will be dispensed with trial contact lenses. Only **unopened and unmarked** boxes can be exchanged. The cost of an annual supply of contact lenses vary depending on the type of contact lens needed to best correct your vision. The cost will be discussed with you during the contact lens exam. **Prior to ordering your contact lenses, a 50% non-refundable deposit is required.**

Contact Lens Prescriptions

Contact lens prescriptions will be released to the patient following the contact lens evaluation and successful fitting of trial lenses. **PRESCRIPTIONS ARE VALID FOR ONE YEAR.** Please note that contact lenses can only be ordered with a current contact lens prescription.

If the contact lenses are purchased **after 90-days re-examination and/or re-fitting fees apply** to analyze the prescription. It is imperative that you obtain your prescription in a timely manner, **before 90-days. A minimum evaluation fee of $80 applies for contact lens re-evaluations outside of the 90-day prescription guarantee period.**

PATIENT ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT THERE IS AN ADDITIONAL MINIMUM FEE OF $80 FOR THE CONTACT LENS PRESCRIPTION AND UNDERSTAND IT IS DUE AT THE TIME OF SERVICE.

_____I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A MINIMUM OF $80.00 FOR MY CONTACT LENS PRESCRIPTION AND REQUEST TO HAVE THE CONTACT LENS FITTING IN ADDITION TO MY EYE EXAMINATION.

_____I DO NOT WISH TO HAVE A CONTACT LENS FITTING AND MY CONTACT LENS PRESCRIPTION. I WILL NOT RECEIVE A NEW CONTACT LENS PRESCRIPTION IF I DO NOT HAVE THE CONTACT LENS FITTING IN ADDITION TO MY EYE EXAMINATION.

Printed Name of Patient	Patient Signature	Date

681 Third Avenue, Chula Vista, CA 91910 619/420-2111
FAX Number 619/585-8130

OFFICE USE ONLY: Drs. Initials_____

POS Reorder # 1420722