For Contact lens patients only

Explanation of Contact Lens Fitting/Evaluation Fees

As a contact lens wearer, additional tests are provided for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and Doctor each year to properly evaluate your contact lenses. Contact lenses are prescribed medical devices that require a yearly fitting/evaluation and an updated prescription.

Contact Lens Fees - New and Established patients

- **Level 1 Fitting Fee - $65.00 New and Established patients –** Spherical (distance only) when corneal health is stable**.**

- **Level 2 Fitting Fee - $95.00 New and Established patients -** Mono vision contacts, Multi-focal contacts, astigmatism contacts, new contact lens wears, RGP fits, patients whose eye health is not stable (dry eyes, allergies and other corneal conditions).

- **Contact Lens Evaluation Fee - $50.00 Established patients only –** When there is little to no change with your current prescription prescribed by this office within a reasonable time from your last exam and corneal health is stable. **This evaluation fee is required in order to receive a prescription for contacts.**

- **Medically necessary contact lens Fitting Fee $125.00- $250.00 - New and Established patients –** Including, but not limited to, aphakia, anisometrophia, keratoconus and other corneal injuries.

All contact lens fits require at least one follow up appointment. The fitting fee includes all follow-up visits pertaining to contacts during the first 45 days. All follow up appointments must take place with 45 days of original fitting to receive a contact lens prescription. Failure to complete your fit during the allotted time will result in an additional fitting fees and/or another exam.

_____ **Yes…** I would like to be evaluated for contacts today. I understand a contact lens fitting is required so that I may wear and order a contact lens supply. I understand that the fitting is a separate service and fee that will be performed annually.

_____ **No…** I am not interested in a contact lens prescription and understand that I will not be able to purchase contacts or receive a contact lens prescription. I understand I will only have 90 days after my exam to return to the office for a fitting or evaluation after the 90 day I will require and be billed for a new exam.

By signing bellow that you agree to Emerald Coast Eye Care fitting/evaluation fee policy and understand that all fees must be paid at time that service is rendered.

Patient Name _____ **Date** _____

Signature (guardian, if minor) _____