COMPREHENSIVE EYE
2855 Jordan Court, Alpharetta, GA 30005
200 Mosaic Circle, Pooler, GA 31322

Annual Contact Lens Agreement

Contact lens Evaluation and Contact Lens Fitting:
Every year, each patient that wears contact lenses must be evaluated for any changes to their vision and their contact lens prescription. The evaluation will include precise measurements, analysis of their visual needs, and recommendations specifically tailored for them.

The **Contact Lens Fit/Evaluation Fee** will range in price depending on the lens type and measurements of your prescription. This charge will be in addition to the comprehensive eye examination fee. The fee will cover the initial evaluation and all contact lens follow-ups for a period of 3 months. Patients can add a contact lens fit/evaluation at anytime to their comprehensive eye exam up to 90 days after the exam. After 90 days, they will be required to complete a comprehensive eye exam before completing a contact lens fitting.

Level 1: Standard Contact Lens New Fit or Re-fit (Sphere) .....$ 70
Level 2: Advanced Contact Lens New Fit or Re-fit (Toric, Multifocal, or Monovision).....$ 100
Level 3: Medical Contact Lens New Fit or Re-fit (RGP, Keratoconus, MiSight) .....$ 150

A **Contact Lens Training** is required if the patient has no previous history of contact lens wear, or if the last contact lens wear has been greater than 5 years ago. The fee for the contact lens training includes up to three thirty-minute sessions for the patient to learn the following: cleaning and hygiene, insertion and removal of contact lens, and wearing schedule. If the patient is unable to complete the contact lens training on their first attempt, they are allowed two more training sessions to achieve success with no extra charge. If after three sessions, the patient is unable to master the training, additional sessions are $20 each.

Contact Lens Training .....$ 40

***All fees are due at time of service.**
***Contact lens prescriptions are valid for 1 year.**

I have read, understood and agree to the terms above:

Patient Name:_____ Patient Signature:_____ Date:_____

If under 18 years old:

Parent Name:_____ Parent Signature:_____ Date:_____