CONTACT LENS AGREEMENT

Contact lenses are medical devices that can cause serious consequences, such as infection, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise. For that reason, there are additional fees associated with the examination and fitting of contact lenses. If, while wearing contact lenses, you experience any pain, unusual redness, discharge, or any sudden change in vision, remove them and call our office. We will attempt to solve your problem, or, when necessary, refer you to the appropriate professional who can. Any medical expenses incurred from these problems are the responsibility of the patient and *not part of your routine follow-up care*.

In addition to your regular eye examination, there is a fitting fee associated with trying new contact lenses. There are hundreds of types of lenses, and the doctor will need to take special measurements and determine which lens type will work best for you. Your initial design fee will cover ocular surface evaluation, diagnostic lenses, lab or shipping fees, fitting analysis and any follow-up visits necessary to obtain a satisfactory fit. If you have never worn lenses before, your fitting will include a class in which new wearers receive instruction on insertion and removal of the lenses and proper care and cleaning of the lenses. Proper care is always necessary. You must care for your lenses as directed and *dispose of them as prescribed*. Over wear of the lenses can lead to the complications described earlier in this agreement. Use only recommended solutions as substitutions may not be compatible with your eyes and must be approved through our office. The fee may also depend on what type of lenses you wear: for example, bifocal contact lenses are more difficult to fit and take longer to adjust and fine-tune than standard lenses. The fit is finalized after the doctor agrees the fit is successful, or if he determines that contact lenses are not an acceptable option for your eyes. Your initial fitting includes up to 30 days of follow-up; any additional visits required to finalize your fit are subject to a per-visit fee. Once finalized, any future lens changes in brand or type will be considered a refit and may be subject to new fees.

After you have been fit with an appropriate lens, you will have the option of buying a supply of lenses that will last up to one full year. You will have to replace lenses as directed, which can range anywhere from daily, to every 2 weeks, monthly, or quarterly depending on the kind of lens worn. Buying a year's supply of contact lenses at one time is beneficial because discounts or rebates may be available, and because you will have the convenience of having new lenses on hand when you need to replace them, so that you are not tempted to wear old, dirty or damaged lenses that can cause harm to your eyes. Also, you will need to keep your glasses current in order to give your eyes periodic breaks as prescribed by the doctor.

Once finalized, per South Carolina state regulations, your contact lens prescription will be valid for up to 1 year. This means you can purchase enough lenses to last for 12 months and no more. After 12 months, the prescription expires. If you want to continue to wear contact lenses, you must return for a comprehensive eye examination and contact lens evaluation. The doctor will verify that your eyes are responding well to contact lens wear, check the ocular surface for any damage and make sure the lenses are still fitting properly and are the correct prescription for your eyes. The doctor will not renew expired prescriptions without first making sure that your eyes are healthy enough to wear lenses. To avoid any inconvenience, make sure your annual examination is scheduled on time so that you do not run out of lenses before you are seen. If you wear contact lenses, this examination must be done annually, *even if your insurance only allows for a 2-year examination interval.*

I completely understand the above agreement and realize my responsibilities concerning my contact lenses.

Signature of Patient (Parent or Guardian, if Minor) Date

OUR FINANCIAL POLICY

Revised 12/28/2011

The Vision Centers are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

Patients must complete all information forms prior to seeing the doctor. A copy of your insurance card(s) may be required for your file. Missed or broken appointments will be subject to a $45 charge without at least a 24-hours notice.

CO-PAY PLANS: If your plan requires a co-payment and we participate, we will accept the designated fees. You are responsible for any deductible and balance your plan indicates in the explanation of benefits. State law and insurance carriers require all deductibles and co-pays to be paid at the time of your visit.

SELF-PAY: Payment is expected when services are rendered unless other financial arrangements have been made prior to your visit.

USUAL AND CUSTOMARY: This is a term developed by the insurance industry to reflect "average charges" from specific geographic localities. The usual and customary amount noted in the explanation of benefits does not accurately reflect individual charges. Therefore, the usual and customary charges do NOT supercede our fees.

PRESCRIPTION GLASSES AND CONTACT LENSES: We are dedicated to providing you with the best possible prescription. If, however, you are not satisfied with your vision, we will make every effort to verify your prescription and make any necessary changes within the first sixty (60) days subsequent to your initial exam. As prescription eyewear is custom made specifically for you, **NO CASH REFUNDS** will be given; store credit may be given at the discretion of management. Prescriptions not filled in our dispensary are subject to a re-evaluation fee, if necessary.

"I acknowledge my responsibility for payment of all fees regardless of the insurance I may have to assist me. The only exception will be charges for services covered under a contractual agreement that has been entered into between the Vision Centers and an insurance company, HMO, or other managed care entity. **If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.**"

X _____ **Date:** _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

Please Check All That Apply

____ We may discuss your protected medical information with _____.

____ We may leave messages concerning your protected medical information on an answering machine and/or voice mail

____ We may **not** leave any messages on an answering machine and/or voice mail

I am aware of the Notice of Privacy Practices and had the opportunity to review it, upon my request.

Signature:_____ **Date:** _____

Print Name: _____ **Birth date:** _____