FRONT RANGE
EYE PHYSICIANS
205 S. Main St., Suite D - Longmont, CO 80501
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CONTACT LENS – PATIENT AGREEMENT FORM

Contact lenses can provide excellent vision and cosmetic results for many patients. However, they are foreign objects placed on the eye, which can damage the eye if improperly fit or over-worn.

Established Patients:

Established patients must have their contact lenses checked on a yearly basis to ensure healthy eyes and proper vision correction. There is a $35 fee for the annual contact lens check-up, which includes the initial visit plus one additional (adjustment) visit.

New Patients or First Time Contact Lens Wearers:

All new patients and first-time contact lens wearers must have a full eye exam prior to contact lens fitting. In addition to the fee for the eye exam, a fitting fee is charged, which includes the following:

- the fit process
- a training session
- all trial lenses
- a **60-day** free follow-up period, to take care of any necessary changes or problems that arise

Lens Type	Initial Fit Fee - Soft	Initial Fit Fee – Gas Perm
Spherical	$80	$100
Toric	$120	$140
Multifocal	$150	$170

Financial Policies:

- All fees are due at the time of service.
- All outstanding balances for the patient and his/her family must be paid before contact lenses will be ordered or dispensed.
- If you are unable to adjust to your trial lenses after your fitting and your training session, you are still responsible for the usual fee.
- If you still cannot adjust to the lenses after follow-up with the doctor, you may be refunded HALF of the total usual fee.

Replacement of Lost/Damaged Lenses:

If you tear, break, or lose a lens, we will replace up to 2 disposable lenses FREE and 1 daily wear soft or gas permeable lens FREE within **60 days** of purchasing your lenses. After receiving these free replacement lenses, you must pay for future replacements when you pick them up.

AGREEMENTS:

First Time Contact Lens Wearer:
I understand that my contact lenses will be dispensed to me only upon successfully completing a scheduled contact lens training session.

Disposable Contact Lenses:
I agree to adhere to the doctor's recommended wear and care schedule.

Toric and Multifocal Soft Contact Lenses:
I understand that Toric and Multifocal Soft Contact Lenses are often difficult to fit and may require additional fittings and/or adjustments. Should difficulties arise during the **60-day** free follow-up period, the doctor will make adjustments. In such cases, an exchange of contact lenses may be necessary.

Monovision Contact Lenses:
I understand the recommendations for and the risks involved in wearing Monovision Contact Lenses. Should I be unable to adapt to Monovision during the **60-day** free follow-up period, the doctor will make adjustments. In such cases, an exchange of contact lenses may be necessary.

Vision Correction:
I understand that the use of contact lens(es) may not correct my vision to 20/20.

Parent/Minor (under age 18) Patient Responsibility:
I, as the parent or legal guardian of _____, am aware that my minor child is purchasing contact lenses. I agree to assume full responsibility for ensuring that my child understands and follows all instructions (written or oral) regarding contact lens handling, care, and follow-up.

****NOTE: If your contact lenses are giving you problems (discomfort, blurred vision, red eyes, or discharge), discontinue contact lens wear and call our office at the above number.**

ALL CONTACT LENS PATIENTS SIGN:

_____ _____
Customer Printed Name Customer Signature

_____ _____
Staff Signature Date