PATIENT NAME: (LAST) _____ (FIRST) _____ **DATE OF BIRTH:** _____/_____/_____

CONTACT LENS EVALUATION AND MANAGEMENT CONSENT FORM

- **All patients receiving contact lenses and contact lens prescriptions from LIFETIME EYECARE will be charged a separate professional fee for contact lens related services.** Vision & health plans DO NOT include contact lens services as part of their standard eye health & eyeglass examinations, and our fees are structured accordingly. Some vision plans do offer full or partial coverage on contact services and/or a discount. Examining a contact lens patient requires additional time and expertise for the doctor and staff. Additional services for contact lens wearers include: keratometry (corneal curvature measurements); tear film function; slit lamp biomicroscopy (analysis of the lids, cornea, surrounding tissues); calculation of appropriate diameter, thickness, curvature and power of contact lenses; instruction in application, removal and disinfection; and post-fit evaluation of function and eye health.

- **The contact lens evaluation fee (or the appropriate co-pay) is due at the time of service**.

CONTACT LENS EVALUATION AND MANAGEMENT FEES WITH SUGGESTED LENS CATEGORIES.
Your doctor will select the level based upon the complexity and time involved in fitting your type of lenses.

Level 1	**$72**	**CURRENT LIFETIME CONTACT LENS PATIENT OR NEW WEARER OR REFIT INTO NEW LENS** Soft Spherical Lenses *(Includes up to **2 follow-up visits** related to CLs for **30 days**)*
Level 2	**$92**	Soft Toric (for astigmatism) Monovision Rigid Gas Permeable (RGP) Sphere *(Includes up to **3 follow-up visits** related to CLs for **60 days**)*
Level 3	**$110**	High Power & Custom Toric Bifocal/Multifocal Specialty RGP *(Includes up to **3 follow-up visits** related to CLs for **60 days**)*

Additional office visits over the specified limits will be subject to a per-visit fee as indicated by your doctor.

By signing below you are acknowledging that you have read and understood our contact lens program and agree you will pay in full at the time of service.

_____ **I would like to have a contact lens evaluation today.**

_____ I do not want a contact lens evaluation. I understand only my eyeglass prescription will be evaluated, and I cannot order contact lenses.

SIGNATURE (PATIENT OR PARENT/GUARDIAN):_____ DATE: _____