CARTY EYE ASSOCIATES

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Dear Contact Lens Patient:
This is the office policy for all our patients who wear contact lenses. We ask that you **read** and **comply** with the policies listed below.

1. An initial fee is charged for new patients whether presently in contacts or here to be fitted with contacts for the first time. Upon completion of the initial fitting period of 6 months, all professional services and materials will be the responsibility of the patient.
2. Contact lens evaluations and/or fitting charges may not be covered by your insurance plan. These are the minimal annual fees, if there is no insurance coverage.

NEW PATIENTS (includes training)		ESTABLISHED PATIENTS	
Spherical Fit	$100.00	Quick Contact Lens Check	$ 50.00
Astigmatism Fit	$130.00	Refit Simple	$ 65.00
Bifocal/Mono	$130.00	Refit Extended	$ 80.00
RGP Fit Simple	$125.00	Refit Complex	$100.00
Complex RGP Fit	$150.00		

SPECIALTY LENSES

Bifocal Astigmatism	$150.00	Keratoconus	$175.00 per eye

(these fees include contact lens re-checks up to 6 months)

3. All contact lens wearers **must be seen yearly** to assure the health of their eyes. **Contact Lens Prescriptions expire 1 year after the exam** and will not be refilled if exams are not current.
4. Contact lenses will not be ordered if there is an outstanding balance on account for services that have been performed. Contact lenses will not be dispensed or mailed to the patient without payment.
5. Contact lens prescriptions can only be released after the doctor has determined that the initial fitting period has been successfully completed and all fees are paid.
6. It is the general policy of our office that **we do not recommend overnight wearing of contact lenses,** due to the high risk of possible infections. We do suggest that contact lens patients have a current prescription pair of glasses.

If you have any questions about your contact lens care, please call our office. We will be happy to assist you.

I **HAVE READ AND UNDERSTAND THE CONTACT LENS POLICY OF CARTY EYE ASSOCIATES**.

Patient Name (please print) ____

Patient Signature ___________________________________date__________________

Parent Signature (if patient is a minor)_________________________________

7/2010