

Contact Lens Wearer Agreement Form

Lake Point Vision

Thank you for choosing our office for your contact lens needs. Contact lenses can improve the quality of your life; however, they are FDA classified medical devices which, like drugs, provide benefits while posing certain risks. The information in this form and the verbal instructions provided to you by our doctor/staff are important tools in being a successful contact lens wearer. Please read this completely and call our office for any questions or concerns.

CONTACT LENS FITTING

Our doctors will perform an evaluation and assessment of:

- Visual needs and expectations, any contraindications to lens wear
- Determination of prescription and external eye health in regard to tear film and lid hygiene
- Diagnostic trial lens fitting in the eye, determination of appropriate lens power and design
- Assessment of ocular response to lens wear
- First time contact lens wearer will be professionally trained by staff on proper insertion and removal of lenses and cleaning and care of the contacts.
- The fitting fee is not usually covered by many insurances. Some insurance will allow patients to apply the fitting fee towards the contact lens allowance. This fee is due in full at the time of the fitting evaluation and is not a refundable service once rendered.
- A contact lens fitting and evaluation is required annually to maintain healthy contact lens wear and updated prescription.

PROGRESS EVALUATION & CONTACT LENS PRESCRIPTION RELEASE

◇ During the progress exams, the doctor will monitor your eye health in regard to the contact lens, prescription accuracy, and appropriate fit. The doctor may occasionally have to refit the lenses as he/she deems necessary to achieve a better fit.

◇ The final contact lens prescription is only released when **both** the doctor and the patient are satisfied with the vision, comfort, and fit of the lenses.

◇ The fitting fee includes the initial visit and all subsequent visits directly related to contact lens wear within **3 MONTHS** of the initial comprehensive exam. There may be additional office visit charges after the 3 months period or if the patient fails to come back for their follow-up appointment(s) to finalize their prescription. You are responsible for scheduling and attending progress visits in order to finalize your prescription.

◇ **Contact lens prescriptions expire after one year in the state of Texas.** We will release your contact lens prescription provided:

- You have had a contact lens exam within the last 12 months at our office
- You have returned for all requested progress visits allowing the doctor to finalize your prescription
- An ocular medical condition does not exist requiring a follow up visit
- All financial obligations have been met

PATIENT RESPONSIBILITY

I have carefully read and understand the above information. I understand that my contacts are a medical device and must be used and cared for properly. I have been instructed in the proper methods of lens care and handling. I agree to follow the advised wearing and replacement schedule for safe wear. I understand that contacts have a limited useful lifespan and that I risk eye irritation, infection, corneal injury, and possible vision loss and blindness if I exceed the wearing and replacement schedule prescribed by my doctor. I will remove my contact lenses and seek care immediately if I experience eye pain, redness, discharge, sensitivity to light, decreased vision, or other significant or unusual symptoms. I understand that I may not be able to wear contact lenses successfully and that lens wear may have to be terminated. I further understand that there are alternatives such as prescription spectacles available to me to correct my refractive condition.

If being fitted with monovision/ bifocal contact lenses, I understand that this may require more adaptation time before attempting potentially dangerous tasks such as (but not limited to) driving or working with machinery. I will resume these tasks only after I have achieved complete visual adaptation and comfort.

I acknowledge that I have read, understood, and received a copy of this agreement. I agree to adhere to the advice, instructions, and policies provided in this agreement.

Patient/ Patient's Guardian Signature

Date