



Contact Lens Policies

Contact lenses are considered “medical devices” and are regulated by the FDA. Careless handling may lead to serious infection, permanent damage to your eyes, and even permanent vision loss. Due to this risk, it is recommended that all contact lens wearers have a current pair of glasses for use when contact lens wear is not desired or safe. **Arizona state law requires contact lenses to be re-evaluated each year in order to renew your prescription and to ensure a proper and healthy fit.**

A contact lens exam shall include: all trial contact lenses, a starter cleaning kit, insertion and removal training (if necessary), and all follow up visits needed to obtain the final contact lens prescription. All NEW contact lens wearers will be trained on how to insert, remove, clean, and disinfect their contact lenses. Each patient must be able to safely insert and remove their contact lenses before they are able to take any trial contact lenses home. **Once a patient has taken home their trial contacts, no refunds will be given for the contact lens fitting.**

This policy requires good compliance of follow up visits by the patient, and is limited to 90 days from the start of fitting. If the patient does not return for scheduled follow up visits, or returns after the 90 day period in an attempt to finish the fitting process, an additional follow up visit charge will be added, or a new exam may be required in order to finalize the contact lens prescription. This decision is at the discretion of the doctor.

Contact Lens Exam Fees


Please be aware that some vision plans **DO NOT** cover a contact lens evaluation, or they charge an additional copay for contact lens evaluations. If this is the case and you elect to proceed to obtain a contact lens prescription, these fees will be considered an out-of-pocket expense to you.

Level 1 Exam: \$50.00 Spherical Contact Lens Fits

Level 2 Exam: \$60.00 Toric (Astigmatism), Monovision, Multifocal Contact Lens Fits

By signing below, I acknowledge that I understand these policies and will adhere to all the conditions noted above.

Patient Name: _____

 Signature: _____ Date: _____