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Contact Lens Patient Program and Policy

At Peak Vision Clinic, we are dedicated to providing you with a quality, healthy, and safe contact lens experience. In order to meet the high standards set forth by our doctors, all patients interested in wearing contact lenses must undergo a contact lens specific evaluation and fitting. Because contact lenses are considered FDA-approved medical devices, our doctors must provide additional care in evaluating and ensuring that the eyes are healthy enough to begin or continue wearing contact lenses. In compliance with the general standard of care in the State of Oregon, we require an eye health and vision examination every year for patients who wear contact lenses. Please note, the annual eye health examination is separate from the contact lens evaluation and fitting process. Additionally, annual contact lens evaluation and fittings must be initiated within 90 days of your annual eye health exam to assess your candidacy for contact lenses.

	ow-up visits may be necessary to trial new lenses and/or monitor eye days of your initial contact lens fitting to finalize your contact
Contact Lens Evaluation & Fitting Process Fees	Spherical: \$
	Toric: \$
	Bifocal: \$
prescription and eye health needs. The type of prescription complexity of an evaluation.	•
*Contact lens prescriptions expire <u>one year from the date of</u> companies do not cover the contact lens evaluation portion service rendered.	f your contact lens evaluation and fitting. *Most insurance of the exam and payment for the evaluation is due at the time the
*Contact lens evaluation fees are non-refundable once the p	process has been initiated.
Contact Lens After-Care — \$45	
day period. If you require additional office visits outside of	hay become necessary for follow-up visits beyond the standard 90 the 90 day period, or if you feel a change needs to be made to your diper after-care visit. This service covers additional follow up visits
Contact Lens Insertion and Removal Training — \$5	50
•	This one-on-one contact lens insertion and removal training is not e applies to each training visit lasting no more than one hour.
I have read and understand the above fees and accept responsibile evaluation and training services performed today. I also understate to pay for any remaining balance that is unpaid by my insurance, prescription for contact lenses will be released to me when the fitter	and that if my insurance is billed for my evaluation, it is my responsibility I am aware that the above fees are non-refundable and that my
Patient Name	Physician Name
Signature	Date
Guardian Name (if applicable)	Relationship to Patient
Guardian Signature	