

## OMNI VISION CONTACT LENS AGREEMENT

*The contact lens (CLs) professional fitting fee is a one-time fee and non-refundable.  
There are different fees for different kinds of CLs. We will let all patients know this fee prior to fitting.*

### *YOUR CLs PROFESSIONAL FEE INCLUDES:*

1. CLs Fitting: This fitting visit includes a trial pair and a contact lens case
2. Follow Up Visits (if necessary): we want to provide the best comfort and vision for your eyes. You can have as many visits within 30 days as necessary to make your contact lens wear experience exceptional. A new fitting fee will be charged after 30 days.
3. Modifications/Refits (if necessary): if it is necessary to refit you with a different type of lens in order to achieve a successful fit within the 30-day period, you will only be charged the difference in lens cost and professional fee.

### *OTHER POLICIES:*

1. Special Office Visits: office visits outside the normal contact lens follow-up care are not included. For example: red eyes, allergic eyes, irritated eyes, etc.
2. Credits: In the event that the doctor decide that it is necessary to discontinue wearing contacts, the following credit policies apply:
  - A. Professional fees (exam and CLs fitting) are non-refundable.
  - B. The cost of the contact lens materials minus a handling fee (\$25 for soft CLs, \$50 for each corneal RGP, \$100 for each hybrid or scleral lens) will be credited to your account.
  - C. Contact lenses must be returned undamaged and boxes unopened.
3. New CLs wearer: ALL first time contact lens wearers are required to attend the Insertion & Removal (I&R) class with us. There is an additional fee of \$20 for this I&R class. This fee is not covered by insurance.

### *CONTACT LENS CARE INSTRUCTIONS*

*As a contact lens wearer:*

1. I will maintain good hygiene when handling contact lenses
2. I understand the proper way to clean and disinfect contact lenses and the case
3. I understand the importance of long-term follow-up care
4. I will not swim with contact lenses
5. I should have a pair of back up glasses and a pair of quality sunglasses
6. I understand the wearing/replacement schedule of the prescribed contact lens
7. I will contact the office immediately if there is any eye emergency

I acknowledge that I have received and understood the Contact Lens Agreement. I will follow the contact lens care instructions given to me by Omni Vision doctors and/or staff. I have also been informed of the necessity for periodic examinations to monitor my eye health and condition of my contact lenses. It is my understanding that improper use and inadequate care of the contact lenses can possibly cause eye irritation, infections, and corneal injury.

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN NAME (if patient is <18 years old): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_