CONTACT LENS FITTINGS

Definitions:

***CL NEW FIT**: New patient not seen previously at KEC. Fees include fitting, 1 set of trial lenses and follow up care for 90 days.

***CL RE-FIT**: A patient seen previously at KEC for contact lens services or patient has valid documented contact lens information from previous fitting exam. Patient prescribed same brand and material type (only power change). If brand or material type change, patient is considered a **NEW FIT AND NEW FIT FEE SCHEDULE APPLIES.**

Contact Fitting Fees **DO NOT INCLUDE:** *Refraction Fee *Cost of Comprehensive Exam *Cost of the contact Lenses	**NEW FIT:** Price include training and follow up visits	**Annual Contact Lens Exam:** No problems or changes in the lenses.

CONTACT LENS TYPES

Soft Lenses	$120.00	$80.00
Sperical- Low Cylinder Soft Toric	$200.00	$80.00
Specialty Fit- Mono vision, Multi focal, Bi-Toric, Front Toric	$275.00	$90.00
High Cylinder Soft Toric (+2.25 or Higher)	$250.00	$90.00
Medical Fits Keratoconus/ Abnormal Cornea	$600.00	$250.00
Sclera EZ Fit Dry Eye	$350.00	$250.00
Regular RGP HYBRID	$300.00	$250.00

BY LAW WE CANNOT GIVE OUT CONTACT LENS PRESCRIPTION UNLESS WE HAVE SEEN THE PATIENT AND FIT THEM WITHIN THE LAST YEAR.

PAYMENT

Fees for the contact lens fitting is due at the time of the initial visit and is **NON REFUNDABLE**. Your insurance will not be billed, unless we know ahead of time that this is a covered benefit. Contact lens orders will be placed with our optical department- a down payment may be required, due to the type of lenses. Please see an Optician for details on your specific order once your fit has been completed.

REFUNDS

There will be no refund on custom lenses, opened boxes or colored lenses. If, however, the doctor decides to discontinue the patient's contact lens use, a full refund of the unopened box will be given. **NO** refunds will be given for the exam, fitting or annual contact lens checks.

I have read and understand the contact lens policy and my financial obligation prior to starting the contact lens fitting. All of my questions have been answered, and I have received a copy of this form for my records.

Patient Name:_____Date:_____

ACCT NUMBER: _____