Columbus Ophthalmology Associates
Annual Contact Lens Agreement

At **Columbus Ophthalmology Associates**, we carry the latest in contact lens technology and specialize in the difficult-to-fit patient. This includes astigmatism-correcting lenses (toric), multifocal lenses, corneal diseases (like keratoconus) and post-surgical contact lens fits. Whether you need a standard or advanced fit, contact lenses are a medical device and we are dedicated to your eye health and a comfortable contact lens experience.

A **Contact Lens Fit Evaluation** or **Re-fit Evaluation** is necessary every year to determine the contact lens prescription and is in addition to the comprehensive eye examination fee. This evaluation will include precise measurements, analysis of your vision needs and recommendations specifically tailored for you. This fee will include the initial visit and any contact lens related follow up visits for a period of 90 days and is non refundable. It may also include diagnostic lenses and contact lens training of insertion and removal when necessary. New or secondary complaints that arise during the process of fitting may be billed accordingly and are not necessarily covered under the fitting fee. Follow ups beyond 90 days will be charged a refit fee.

The **Contact Lens Fit Evaluation** or **Re-Fit Evaluation** fee will range in price depending on the complexity of the contact lenses worn:

- **Standard** Contact Lens Re-fit Evaluation (Soft Spherical)……..$69
- **Advanced** Contact Lens New Fit or Refit (Toric, Monovision)……..$99
- **Superior** Contact Lens New Fit (New Wearer) or Refit (RGP, Multifocal, Hybrid)….$149
- **Medical** Contact Lens New Fit or Refit (CRT, Post Surgical, Keratoconus)……..$199

Note: Follow-up visits may not be included in some Medical Fits

Contact lens prescriptions are valid for **1 year** and will be released after any necessary follow up visits with the doctor have been completed.

I have reviewed this policy on contact lenses and agree to abide by the terms stated here or risk injury to my eyes and vision.

Patient Name (Printed)_____

Patient Signature_____

Date_____