Yardley Vision Care Contact Lens Consent Form

I understand that contact lenses are an addition to the standard health exam and, as such, there will be an additional fee associated with the fitting. I understand that my insurance may not cover all of this fee. My evaluation fee covers any follow-up visits related to routine contact lens fitting completed within 90 days, subject to discretion. It is my responsibility to complete all follow-up care within this time, following the timeline set by the doctor. Additional fees may be accumulated for care outside of the 90 days or any visits related to medical complaints. I understand that contact lenses are a medical device and my prescription cannot be finalized until all follow-up care is completed. Per Pennsylvania law, contact lens prescriptions expire 1 year from the date of the evaluation and cannot be extended.

I acknowledge that I have been instructed in the proper manner of insertion, removal, and care for my contact lenses. Contact lenses are a medical device sitting on living tissue. I have been made aware of the risks associated with over-wearing my contact lenses, and have asked for clarification if needed. I understand that noncompliance in wearing schedule may result in serious injury to my eyes.

I understand that any prolonged pain or redness should be reported to this office immediately. Failure to do so may result in serious injury to the eye and possible permanent loss of vision. I understand that follow-up care is of the utmost importance and it is my responsibility to ensure that I follow the plan set by my doctor.

I understand all fees must be paid for at the time of visit.

Contact lens fitting: The fitting fees for new wearers are as follows:

a) Spherical $90
b) Astigmatism $105
c) RGP/Specialty $105*
d) Bifocal $140
e) Monovision $115

Contact lens annual fee: After your initial fitting, you will need an annual contact lens exam to maintain your contact lens prescription. The contact lens evaluation may not be covered by your vision insurance. The fees for your contact lens evaluation are as follows:

a) Spherical $50
b) Astigmatism $55
c) RGP/Specialty $65*
d) Bifocal $65
e) Monovision $55

*Prices may vary

Print Name: ____ (Parent if under 18 years)

Signature: ____ Date: _______________