



Contact Lens Evaluation Fees

Insurance plans charge a separate copay for contact lens evaluations. If you have questions about your contact lens evaluation copay, please contact a member of our staff.

The below fees are the price for cash pay cases. The fee is based on the difficulty of the case, including but not limited to the examples listed. A patient may be bumped up a level for a more difficult case.

Level 1: \$58.82	Follow up only
Level 2: \$82.35	Soft Spherical evaluations; moderate complexity (no training)
Level 3: \$117.65	Toric evaluation w/astigmatism; normal range < -2.25 cyl, First-time spherical wearer (includes training), Monovision
Level 4: \$152.94	Gas Permeable (RGP), Synergeyes, Bifocal soft/hard evaluations (no training), Toric evaluations w/astigmatism; extended range > -2.25 cyl, First-time toric wearers (includes training)
Level 5: \$188.23	New wearers of RGP, New wearers of Bifocal, Bitoric evals (includes training)

Annual Contact Lens Supply Program

These are the benefits enjoyed by patients who purchase their annual supply from Sun Valley Eye Care

- No shipping/handling fee on contact lens orders
- If you are past your exam due date but can't come in, we will provide you with trial lenses until your exam date, within 1 month
- Mail in rebates up to \$300 (available on select lenses only)
- Up to 60% promo frame and lens packages. See sales associate for more details

Contact Lens Survey

This form is used to help us understand how your current contact lenses are working for you. By having all the data collected, we can come up with a plan of action that will best suit your needs.

Patient Name: _____ Date: _____

Current contact lens brand: _____

Place where you purchased them: _____

1.

2. **Do you need improvement in vision in your current contact lenses?**

Yes No Not sure

3. **Is this brand of contacts comfortable on your eyes?**

Yes No Not sure

4. **What is your average wearing time per day?**

0-4 hr 4-8 hr 8-12 hr 12-16 hr
16+ hr Overnight

5. **What is your actual replacement schedule?**

Daily 2 weeks Monthly 2-3 Months
Yearly When they hurt

6. **What bottle do you use to disinfect/soak your lenses overnight?**

Opti-Free (green) Bio-True
Revitalens Clear care (peroxide)
Generic Not Sure

7. **Do you rub your lenses to clean them?**

Yes No Sometimes

8.

Do you use rewetting drops/ artificial tears with your contacts?

Yes No Sometimes

9. **Would you like to wear the same brand again?**

Yes No Maybe

10. **Do you wear sunglasses over your contacts?**

Yes No Sometimes

11. **How often do you wear your contacts?**

Everyday 3-5 days per week
Less than 3 days per week

12. **About how long do you wear your contacts before you feel them?**

3-4 hours 5-6 hours 7-8 hours
9-10 hours 11-12 hours 13+ hours

13. **If you don't currently wear daily contact lenses, would you be interested in trying them?**

Yes No Maybe

I, _____ would like to be evaluated for a contact lens examination. I understand contact lens exams are in addition to a regular eye exam and the fees associated with it are based on complexity of the case. I understand that requests for contact lens prescriptions will only be honored for one (1) year.

I agree that **my two follow-up visits, if needed, must be completed within 30 days** from my initial date of service, otherwise an additional fee will be charged.

A pair of trial lenses may be dispensed at your evaluation. There is a \$20 s/h fee for any additional trial lenses when you don't purchase your annual supply with our office.

I confirm that the information given above is accurate to the best of my knowledge.

Patient/Guardian Signature

Date