I, _____ would like to be evaluated for a contact lens examination. I understand CL exams are in addition to a regular eye exam and the fees associated with it are based on complexity of the case.

Level 1: $ 35 Follow-up appts; minimal complexity
Level 2: $ 71 Soft Spherical evaluations; moderate complexity (no training)
Level 3: $105 Toric evaluation w/astigmatism; normal range < -2.25cyl
First-time spherical wearer (includes training), Monovision
Level 4: $140 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: $170 New wearers of RGP, Bifocal, or Bitoric evals (includes training)

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.

With full knowledge of the above, I voluntarily request and consent to be evaluated with contact lenses.

_____ _____
Patient/Guardian Signature Date

Annual Supply Program

Most contact lens orders with our office are now shipped directly to your house for your convenience.

3-6 mos.	1 year	**Annual Supply Program Benefits**
$7	Free	• Ship order to your house.
$10-$20	Free	• Trial pairs. If you are short on lenses we will replace them free of charge until your next exam. If you are past your exam due date, but can't come in, we will give you lenses until your exam date (within 1 month.)
N/A	Yes	• Rebates. Mail-in rebates up to $100. (Available on select lenses only.)
N/A	Yes	• 30% off non-prescription sunglasses.
N/A	Yes	• 50% off promo frame & 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: _____

Name of your contact lenses:_____

What is your Rx?_____

Place where you purchased them:_____

Please indicate which answer is best.

1. Do you need improvement in vision in your current contact lenses?
   ○ a. Yes ○ b. No ○ c. Not sure

2. Is this brand of contacts comfortable on your eyes?
   ○ a. Yes ○ b. No ○ c. Not sure

3. What is your average wearing time per day?
   ○ a. 0-4 hrs ○ b. 4-8 hrs ○ c. 8-12 hrs ○ d. 12-16 hrs ○ e. 16+ hrs ○ f. Overnight

4. What is your actual replacement schedule?
   ○ a. Daily ○ b. 2 weeks ○ c. Monthly ○ d. 2-3 Months ○ e. When they hurt ○ f. Yearly

5. What bottle do you use to disinfect/soak your lenses overnight?
   ○ a. Opti-Free (green) ○ b. Renu (blue) ○ c. Complete (blue) ○ d. Clear care (peroxide)
   ○ e. Generic ○ f. Not Sure

6. Do you rub your lenses to clean them?
   ○ a. Yes ○ b. No ○ c. Sometimes

7. Do you use rewetting drops/ artificial tears with your contacts?
   ○ a. Yes ○ b. No ○ c. Sometimes

8. Would you like to wear the same brand again?
   ○ a. Yes ○ b. No ○ c. Maybe

9. Do you wear sunglasses over your contacts?
   ○ a. Yes ○ b. No ○ c. Sometimes

10. How often do you wear your contacts?
    ○ a. Everyday ○ b. 3-5 days per week ○ c. Less than 3 days per week

11. At what time of day do you start to feel your contact lenses?
    ○ 12pm ○ 1pm ○ 2pm ○ 3pm ○ 4pm ○ 5pm ○ 6pm ○ 7pm ○ 8pm ○ 9pm ○ 10pm ○ 11pm