sun valley eye care

Contact Lens Evaluation Fees

The below fees apply 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 2: $71	Soft Spherical evaluations; moderate complexity (no training)
Level 3: $105	Toric evaluation w/astigmatism; normal range < -2.25 cyl, 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, New wearers of Bifocal, Bitoric evals (includes training)

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

Annual Contact Lens Supply Program

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

- **Free non-prescription sunglasses for daily contact lens wearers. Select brands, see sales associate for more details**
- 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 $200 (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: _____

Current contact lens Rx: (ie BC, DIA, SPH, AXIS, CYL) _____

Place where you purchased them: _____

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

◉ Yes ○ No ○ Not sure

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

○ Yes ○ No ○ Not sure

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

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

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

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

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

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

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

○ Yes ○ No ○ Sometimes

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

○ Yes ◉ No ○ Sometimes

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

◉ Yes ○ No ○ Maybe

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

◉ Yes ○ No ○ Sometimes

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

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

11. **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

12. **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.

Exam copay: _____

CL Eval: _____+/max

CL Supply: _____

If combined, supply allowance is reduced to: _____

_____ _____

Patient/Guardian Signature Date