Dr. Helen Knisley & Associates Date:_____

Office Policies/ Agreement Form

FILL OUT ALL AREAS THAT APPLY TO YOUR VISIT

Fill out if wanting a CONTACT LENS EVALUATION

1)I understand the goal of a contact lens evaluation is to find the most appropriate contact lenses for each patient, optimal in vision and comfort. Many patients will only need one fitting session, while others may require extra sessions. 2) I understand the contact evaluation is **annual**, with an **annual fee**, separate from the routine eye exam. 3)I am aware that this service may or may not be covered by my insurance. The amount of this fee is determined by the complexity of the lens type and specialized knowledge needed to fit the lenses. 4) I also understand, should I not return for my contact lens follow-up visits, within **30 days of exam date**, I will **not** receive a valid contact lens prescription and I will also be subject to a refitting fee of $30. 5) Should I want to switch lens type/brand after prescription finalization I will also be subject to a $30 fee. 6) For first time contact lens users a $30 fee will be added for an insertion & removal class that is **required** and not covered by insurance.

Contact Lens Order Returns: Any and all opened boxes of contact lenses, **cannot** be returned, exchanged or refunded. **All** colored contact lenses (opened or unopened boxes) cannot be returned, exchanged or refunded. **All** returns/exchanges/canceled purchases will be subject to a 25% restocking fee and must occur 60 days from purchase date.**

I have received my contact lens prescription: Initial_____

_____ _____

Print Patient Name **Patient/ Guardian Signature**

Fill out if wanting a COMPREHENSIVE EYE EXAM

1) I understand that should I have any issues with my glasses prescription I have up to 60 days to return for a recheck at no charge. 2) I understand if it has been more than 60 days (up to 120 days) from the initial exam date I will be subject to a $30 glasses recheck fee. 3) I understand if it has been more than 120 days I will be required to perform a NEW comprehensive eye exam at full price or use my vision insurance if applicable.

_____ _____

Print Patient Name **Patient/ Guardian Signature**

Fill out if wanting a MEDICAL OFFICE VISIT

1) I understand that an office visit is a medical exam and NOT a comprehensive vision exam, therefore, I will not receive a spectacle or contact lens prescription. 2) I understand that my vision insurance **cannot** be billed for a medical exam. 3)The initial visit ranges from $90-$115, any follow-ups needed will be an additional $30 per office visit follow-up.

_____ _____

Print Patient Name **Patient/ Guardian Signature**