Dr. Helen Knisley & Associates
Office Policies Form
Please fill out all areas that apply to your visit.

Routine Eye Exam

1. I understand if 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 from the initial exam date, I will be subject to $30 glasses recheck fee.
3. I understand if it has been more than 120 days, I will be required to perform a NEW routine eye exam at full price or use my vision insurance if applicable. If returning for a contact lens rx/eval another day it must be done within 30 days of the initial routine exam to avoid a $30 fee on top of any copays/fees.

I understand that there are no refunds on services rendered.

I have received my glasses prescription:(signature) _____

_____ _____

Print Patient Name **Patient OR Guardian Signature**

Contact Lens Fitting/Evaluation

1. I understand many patients will only need one fitting session, others may require extra sessions.
2. All follow-ups must be done within 30 days of exam to avoid a $30 follow-up fee (new exam after 120 days).
3. I understand the contact lens evaluation is separate from the routine eye exam.
4. I understand this service may or may not be covered by my insurance. The fee is determined by the complexity of the lens type and specialized knowledge needed to fit the lenses.
5. I understand if I do not return for my contact lens follow-ups within 30 days of the exam date, I will not receive a valid contact lens prescription and will be subject to a refitting fee of $30.
6. If I want to switch lens type/ brand after prescription finalization I will be subject to a refitting fee of $30 and any other fees that may apply. **I understand there are no refunds on services rendered.**

First time contact lens users: A $30 insertion and removal class will be required, not covered by any insurance.
Contact Lens Order Returns: All opened boxes cannot be returned, exchanged or refunded. All colored contact lenses (opened or unopened) cannot be returned, exchanged or refunded. All returns/exchanges/ canceled purchases will be subject to a 25% restocking fee and must be done so within 60 days of purchase date.

I have received my contact lens prescription:(signature) _____

_____ _____

Print Patient Name **Patient OR Guardian Signature**

Medical Office Visit

1. I understand that an office visit is a medical exam and not a routine eye exam, therefore I will not receive a glasses or contact lens prescription.
2. I understand that my vision insurance cannot be billed for a medical visit. The initial visit ranges from $100-$125, any follow-ups needed will be an additional $30 each time. **I understand there are no refunds on services rendered.**

_____ _____

Print Patient Name **Patient OR Guardian Signature**