KISIOLEK EYE CENTER
Optometry

Contact Lens Agreement

If you are electing to wear contact lenses, a contact lens exam & fitting will be completed by the doctor with *an evaluation fee based on the complexity of your prescription*. This fee includes the exam & fitting, diagnostic contact lenses if needed, and any additional follow-ups for 90 days unless otherwise authorized by the doctor.

Why do I need a contact lens exam & fitting?

- To determine the proper contact lens prescription based on your individual prescription, vision needs, and corneal health and curvature.
- To evaluate the health of the eye - paying close attention to the cornea, eyelids, and conjunctiva - and how contact lens wear affects the health of the eye.
- To examine the contact lens on the eye to ensure proper alignment with the cornea and lids.
- To measure vision and the contact lenses on the eye and make adjustments as indicated.

Associated Fees:

- **Existing Wearer Fit Fees:** Contact lens exam & fitting services are not guaranteed to be included as part of routine vision benefits and additional yearly fees may apply. Fees/copays are customized according to the complexity of care and the predicted time necessary to care for the patient.
    - Standard CL Evaluation $88.00 (single vision)
    - Specialty CL Evaluation $98.00
    - Specialty CL Evaluation w/Follow-Up $142.00
    - Medically Necessary CL Evaluation $298.00

- **NEW Wearer Fit Fees:** Your first time fee includes contact lens insertion and removal training, trial lenses, and any follow-up visits for first-time wearers.
    - Standard CL NEW Fit $142.00
    - Medically Necessary CL NEW Fit $298.00

I acknowledge that the Kisiolek Eye Center team has informed me of the additional fees associated with electing to wear contact lenses. I agree to pay any associated fees in accordance with my vision plan and/or Kisiolek Eye Center's Financial & Insurance Agreement.

Responsible party for contact lens evaluation fees:

Print Name:	**Signature:*

Insured/Patient Name and Date of Birth (MM/DD/YYYY):

Print Name:	*Birthdate:*
Date:	

Please let us know if you have any questions about our fees and/or what your vision benefits will cover. Thanks for letting us care for you!