NorthShore University HealthSystem Department of Ophthalmology
Patient Contact Lens Service Agreement

All fees associated with contact lens supplies, exams/visits and/or testing are considered "Self-Pay". Payment is due at the time services are rendered

√	Fit Type	Cost	√	Fit Type	Cost
	Basic Fit	$180.00		Keratoconus	$1,200.00
	Toric/ RGP	$225.00		Scleral Lens	$2,400.00
	Specialty Fit	$450.00		Yearly Eval	$75.00

√	Supplies	Unit Cost	Units	Total
	Lenses			

Contact Lens Fits Include:

1. Assessment of the patient's eye(s), the patient's visual and physiological need to determine/recommend the best contact lens type for the patient.
2. Specialized measurements to determine the parameters of the recommended contact lens.
3. Patient training on contact lens insertion, removal, care and maintenance.
4. A contact lens prescription. The contact lens prescription will be dispensed to the patient once the fit is finalized by the doctor. This usually includes the fit appointment and at a minimum one follow-up appointment to check the contact lens fit and assess eye health after the contact lenses have been worn for a recommended amount of time.
5. Fit related adjustments will be included in the fit fee for the length of the warranty of the lens (typically 3 months).

Note: Contact lens prescriptions are valid for one year from the date the fit is finalized and the prescription is dispensed.

Annual Contact Lens Evaluation $75.00 fee:
Patients will need an annual contact lens examination to maintain a valid prescription.
The purpose of this visit is to confirm the current contact lens fit is adequate for the health of your eyes. **This visit is solely for the purpose of evaluating a patient's contact lenses; this is not a comprehensive eye exam.**

Contact Lenses/Supplies Fee's

Most specialty contact lens types are not kept in stock and must be ordered. Payment is due at the time the order is placed.

Note: A patient may choose to submit their receipts of services rendered to their insurance. This is the patient's sole responsibility. Our department does not guarantee reimbursement. Our contact lens services are considered self pay. Patients agree to pay our office 100% of the charges.

I, _____, understand and agree to all policies outlined above.

Signed _____ Date _____

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