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CONTACT LENS AGREEMENT & INFORMED CONSENT

CONTACT LENS FITTING & EVALUATION

Contact lens fitting and evaluation require additional procedures beyond a routine eye examination. The contact lens evaluation includes the selection of the proper lens type and fit, measurement of the curvature of the eye, evaluation of the health of the eye with contact lenses in place, and patient education regarding proper insertion, removal, care, and maintenance of lenses.

PATIENT RESPONSIBILITIES

In consideration of the fitting and supplying of contact lenses by Access Health Vision, I agree to the following terms and conditions:

1. **Follow-Up Visits:** I understand that follow-up visits are essential to ensure proper fit, comfort, and eye health. I agree to return for all recommended follow-up appointments. Failure to keep scheduled follow-up appointments may result in complications that could have been prevented.
2. **Proper Lens Care:** I agree to follow all instructions regarding contact lens care, cleaning, disinfection, wearing schedules, and replacement schedules as prescribed by my doctor. I will use only the solutions recommended by my eye care provider.
3. **Wearing Schedule:** I agree to follow the wearing schedule recommended by my doctor. I understand that overwearing contact lenses or sleeping in lenses not approved for overnight wear can lead to serious complications.
4. **Annual Examinations:** I understand that annual comprehensive eye exams and contact lens evaluations are required to maintain a current prescription and to monitor my eye health.
5. **Notify the Office:** I agree to remove my contact lenses immediately and contact the office if I experience any of the following symptoms: pain, redness, excessive tearing, discharge, blurred vision, light sensitivity, or a feeling that something is in my eye.

RISKS OF CONTACT LENS WEAR

I understand that wearing contact lenses carries certain risks, including but not limited to:

- Corneal abrasion (scratch on the surface of the eye)
- Corneal ulcer or infection (which can result in permanent vision loss)
- Allergic reactions to lens materials or care solutions
- Dry eye or discomfort
- Giant Papillary Conjunctivitis (GPC) — an allergic response under the eyelids
- Neovascularization — abnormal blood vessel growth on the cornea
- Changes in corneal shape that may temporarily or permanently affect vision

These risks are increased by: poor hygiene, sleeping in contact lenses, overwearing, using water or saliva to clean lenses, swimming or showering in lenses, and failure to replace lenses as scheduled.

FINANCIAL RESPONSIBILITY

I understand that the contact lens fitting/evaluation fee is **separate** from the comprehensive eye examination fee. The fitting fee covers the professional services involved in selecting, fitting, and evaluating contact lenses. Contact lens materials (the lenses themselves) are an additional cost.

Contact Lens Fitting/Evaluation Fee: $_____ (This fee is non-refundable.)
Note: Insurance coverage for contact lens services varies by plan. Please check with your insurance provider regarding your benefits.

CONTACT LENS PRESCRIPTION RELEASE

In compliance with the FTC Contact Lens Rule, Access Health Vision will provide you with a copy of your contact lens prescription upon completion of a valid contact lens fitting. Your prescription is valid for one (1) year from the date of your last examination, unless your doctor determines a shorter period is medically necessary.

PATIENT CONSENT & AGREEMENT

I have read and understand the above information. I acknowledge the risks, responsibilities, and financial obligations associated with contact lens wear. I agree to follow the instructions and care guidelines provided to me by my eye care provider.

PATIENT NAME (PRINTED)

DATE OF BIRTH

PATIENT / GUARDIAN SIGNATURE

DATE

LENS TYPE

BRAND / MANUFACTURER

OD (RIGHT) — BC / DIA / POWER

OS (LEFT) — BC / DIA / POWER

PRESCRIBING DOCTOR

RX EXPIRATION DATE