Patient Name _____ Patient #_____

## New Eyeglass or Contact Prescription

*These examinations are NOT covered by medical insurance companies because they are vision services, not medical care services.*

• **The fee to prescribe eyeglasses or contact lenses is $40.00.** This fee must be *collected prior to exam* when a patient requests a prescription for eyeglasses or contact lenses. This fee includes refraction exam, prescription and any rechecks for a period of one year. If trial lenses are required for contact lens wearers, there is a $10 shipping and handling fee.

• **The fee for a new contact lens wearer is $150.00**. This fee includes the refraction exam, the K-reading (which measures the cornea's curve for the new contact lens), possible corneal topography map, instruction on contact lenses placement and care, and follow-up appointments for a period of one year. This fee does not include any additional lenses.

**Today I would like:**

- ○ **Prescription for Eyeglasses $40.00**
- ○ **Prescription for Contact lenses $40.00**
- ○ **New Contact lens wearer $150.00**

**By signing this form, I have read and understand the fees associated with getting a prescription.**

***Signature** (patient or legal guardian):* _____ ***Date***___/___/___