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Contact Lens Service Fee Agreement

A contact lens is a medical device that rests on the surface of the eye. Therefore, it must fit well and be worn properly to avoid any risk to your eyes and vision. A contact lens prescription can only be determined with careful observation by your eye doctor over a series of visits. This will achieve a good fit, lasting comfort and vision. Since follow-up care is essential, it is your responsibility to keep all appointments and to comply with all lens care and lens wear instructions.

Full payment is due at the time your contact lenses are ordered and is non-refundable. We can credit your account for boxes that are returned unopened, non-expired and unmarked. Opened boxes can NOT be returned. Lenses that are custom ordered for you are non-refundable. We will replace any defective lenses but cannot be responsible for lenses damaged from improper handling. Professional fees are **non-refundable**.

First Time Contact Lens Wearer

The contact lens fitting fee is \$150-\$250 for most first time contact lens wearers, depending on the complexity of the case. This includes training you on the insertion, removal, and care of your lenses. It will also cover all follow-up visits within a three month period related to the fitting. This does not cover the cost of the final contact lenses.

I understand that contact lens services may not be covered by my insurance. All related fees are my responsibility and will be paid at the time of service.

X _____

(Signature of patient, or parent or legal guardian if patient under 18 years old)

Established Contact lens Wearer

Your contact lens prescription expires after one year and an annual evaluation is required to renew it. As the eyes do change, it may be determined that you require a contact lens refit if the prescription or the fit is no longer appropriate. If no change is required, there is a standard fee of \$45 to renew your contact lens prescription for another year. If a refit is required, there is an additional fee of \$75 to \$125 depending on the complexity of the case. This will cover all follow-up visits related to the fitting within a three month period. This does not cover the cost of the lenses.

I understand that contact lens services may not be covered by my insurance. This fee is my responsibility and will be paid at the time of service.

X _____

(Signature of patient, or parent or legal guardian if patient under 18 years old)