ADVANCED SIGHT CENTER
www.advancedsightcenter.com

1351 Jefferson Street, Suite 110
Washington, MO 63090-6449
636-239-1650
636-239-9005 fax

12601 Olive Boulevard
Creve Coeur, MO 63141-6313
314-878-4228
314-878-7747 fax

The art & science of clear vision

Contact Lens Policy

Contact Lens Examination and Fitting: At your request, today's examination will include a contact lens fitting, which will be charged in addition to your routine eye exam. A contact lens is a medical device in contact with the tissue of your eye; therefore, it must fit appropriately to maintain the health of your eyes. A contact lens prescription can only be determined by the careful observation of the lens on the eye and the eye's response to the lens on subsequent follow-up visits. Since follow-up care is essential, it is your responsibility to keep all appointments and follow all lens care instructions and wearing schedules.

As part of the contact lens fitting we will evaluate your corneal measurements and dispense trial contact lenses for you to try. If you are a current contact lens wearer we will evaluate their performance and make any necessary changes.

Payment for fitting (or refitting) is due at the time of your initial visit and is non-refundable. This fee covers the fitting of the lenses, trial contact lenses, and instructions on proper care and wearing of the lenses. We do not bill this fee to vision insurance in order for you to receive the most out of your contact allowance.

Payment for contact lenses is due half on ordering and the other half upon delivery of the lenses. Unopened boxes of disposable lenses purchased from Advanced Sight Center may be returned for credit within 30 days. THERE IS NO REFUND OR EXCHANGING ON OPENED BOXES.

Fitting Fees:

New patient or new lens wearer, spherical $110.00
New patient or new lens wearer, toric/bifocal/RGP/monovision $160.00
Established patient, existing wearer, spherical, toric/bifocal/RGP/monovision $60.00

I have read and understand the above terms and conditions and understand the importance of following all directions, caring for my lenses as instructed and returning for all recommended follow-up examinations. Additionally. I understand that I am responsible for all fitting fees and that they will not be billed to my insurance by Advanced Sight Center.

_____ _____

Patient Signature / Guardian Date

_____ _____

Advanced Sight Center Employee Date