Contact Lens Questionnaire

Specifications:

Brand of Contacts: _____ Solution Name: _____

Vision:

Can you see distance and near comfortably with your contacts? Yes No

Life Style:

How many days a week do you wear your contact lenses? _____ days/week

How many hours a day do you wear your contact lenses? _____ hours/day

If you store lenses in solution, do you discard your solution every morning? Yes No

Do you sleep overnight in your contact lenses? Yes No

If you sleep in your contacts, for how many nights in a row? _____ Nights

Do you swim in your contacts? Yes No

Do you shower in your contact lenses? Yes No

Comfort:

Do you experience dryness with your contact lenses? Yes No

Do you have difficulty with seasonal allergies? Yes No

Contact Lens Health History

Have you had a contact lens related eye infection or complication? Yes No

If yes, please explain: _____

Have your eyes become contact lens intolerant over the years? Yes No

Hygiene

Do you have a backup pair of glasses? Yes No

Do you rub your contact lenses with solution when cleaning? Yes No

How often do you change your contact lens case? _____

How often do you change your contact lenses? _____

Please rank from most important to least important so that the doctor can prescribe to best enhance your contact lens experience. (1= Most important, 4= Least important):

_____ Convenience _____ Comfort _____ Clarity _____ Cost

How can we improve your experience with your contact lenses? _____

Contact Lens Fitting Information & Agreement

Contact lenses are FDA Class I medical devices that have the potential for serious complications in not used and fitted properly. For that reason, the standard of care and the requirements for the California State Board of Optometry require an annual examination for renewal of the contact lens prescription.

Patient Eligibility: You must have had a general eye exam within three months prior to obtaining a contact lens fitting. If you had an eye exam outside of Partners Pacific Optometry, your exam records need to be forwarded to us.

Fitting Service Includes: In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poor surface compatibility leading to dry eyes, in addition to any vision changes.

Fitting fees: The **estimated fee** for these services range between **$70.00 and $130.00.** These fees will cover any contact lens related follow ups for two months. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional **$25.00** charge per visit beyond the global time period. *First time contact lens wearer* fees range from $150.00 and $250 to include training for insertion and removal of contact lenses and instructions on proper contact lens care.

Cost of Lenses: The cost of contact lenses is not included in the fitting fee and is determined by the type of lens prescribed by the doctor. It is often difficult to predict the cost of materials before the fit is finalized. We are happy to review the estimated cost of your lens before beginning any fitting process if you request to do so.

Refund: In general, there is no refund for professional contact lens fitting fees. Contact lens materials cannot be refunded after 30 days. Lenses in opened boxes or damaged (i.e. writing on boxes or crushed boxes) may not be returned.

Insurance: Most *medical* insurance plans do not cover contact lenses. *Vision plans* may have contact lens benefits eligibility towards the contact fitting fees and/or materials. Our staff can help you check your eligibility.

Contact Lens Prescription: A contact lens prescription will be released to patients only <u>after</u> the fitting, including follow-up care, has been completed. Contact lens prescriptions by law expire one year from the date we initiate the contact lens fitting.

By signing, I acknowledge that I understand the policies regarding the contact lens evaluation and agree to the associated lens fees. I understand these fees are nonrefundable once the services have been initiated. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Signature: _____ **Date:** _____