NorthShore University HealthSystem

Contact Lens Service Patient Agreement
Division of Ophthalmology

Medically Necessary Contact Lenses: *customized medical devices to optimally correct vision and/or protect the eyes when glasses or other treatments have failed*

All professional fees and contact lens prices subject to change without notice.

X	Visit Type	Professional Fee	Includes
	Contact Lens Related Problem Visits	**$75**	Problem focused examination
	Returning patient or existing contact lens wearer	**No change:** **$75*** **RGP/Soft Toric/Hybrid:** **$150*** **Scleral Change:** **$250***	Vision assessment Cornea check Follow up visits (if necessary, during 90 day lens warranty)
	New Patient Evaluation	**RGP/Soft Toric/Hybrid:** **$225*** **Scleral:** **$550***	Evaluation and consultation Assessment of best correctable vision with RGP Discussion of contact lens options and pricing Diagnostic trial lens fitting Refraction for glasses prescription Training on lens insertion, removal, and care All follow up visits (during 90 day lens warranty)
	Prosthetic (Custom Colored Lens)	**$350***	Evaluation and consultation Training on lens insertion, removal, and care Follow up visits (during 90 day lens warranty)

*cost of contact lenses separate (on average, RGP/scleral lenses last 1 year and hybrid lenses last 6 months)

***Patients with medical or vision insurance**: NorthShore optometrists are not in-network with most medical or vision plans. Contact lens services are considered self-pay. Patients agree to pay 100% of the charges. A patient may choose to submit their receipts of services rendered to their insurance for reimbursement. This is the patient's sole responsibility. Our department does not guarantee reimbursement but will be happy to provide a letter of medical necessity to help support the claim.*

***90-day warranty period:** Customized lenses have a 90-day warranty period allowing for lens modifications as necessary. If a patient decides to discontinue lens wear, they may return the lenses for a refund (**less a $50 shipping and handling charge per lens**) within the 90-day warranty period. Professional fees are non-refundable.*

PLEASE NOTE: *None of the contact lens services replace a comprehensive eye examination; patients must continue care with their routine eye care provider.*

I, _____, understand and agree to all policies outlined above.

Signed _____ Date _____