Progressive Vision Group

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Contact Lens Fitting Agreement

Contact lens fittings and evaluations for new and current wearers are a separate service from your comprehensive eye examination, are considered elective and not always covered by insurance. Contacts have the potential to cause permanent health issues and potential vision loss therefore the health of your eye and the fit of your contacts must be performed every 12 months or, in some cases, more frequently.
North Carolina State law states that contact lens prescriptions expire after 12 months. Contact lenses are regulated by the FDA as a class II medical product and therefore a valid prescription is required to purchase them.

A contact lens fitting/evaluation includes:
*Dispensing of contacts, care kit, instructional material and an insert and removal technique class that includes handling, care and maintenance and answering any questions of proper contact lens care for new wearers.
*2 (two) office visits for prescription modifications within 60 days. Any changes or modifications to the contact lenses or prescription outside of the 2 visits/60 days may incur additional charges.

We cannot be responsible for unsuccessful wear due to patient non-compliance in following care and handling instructions or following the proper wearing schedule.

Trial contact lenses are dispensed for evaluation purposes only. Progressive Vision Group will make allowances to replace torn or damaged lenses on occasion, or supply you with a free trial pair to get you by until an appointment can be made on occasion as well. It is up to you to strictly adhere to the recommended wearing schedule and lens care procedures to ensure your contacts last the entire year, or wear your glasses as needed.
If you experience blurred vision, redness, watering of the eye, sensitivity to light, eye discomfort, or pain, **remove your contact lenses and contact our office right away.**

I have read the contact lens fitting agreement, all of my questions have been answered and I understand and accept the policies.

_____patient name

_____signature of patient/parent/legal guardian