GeorgiaOphthalmology Associates

Contact Lens Policy and Fitting/Evaluation Fees

The following evaluation fees apply if you are a contact lens patient who is new to our practice, or if you are in an existing patient.

Contact Lens Evaluation Fee – includes up to 3 visits,
$25 each for additional visit

Basic evaluation fee -established patient with prescription change,
$25 - $75.00 -established patient whose last exam was more than 12 months ago,
-new patient with known prescription to evaluate if current prescription is correct

Distance Lens evaluation (weekly, monthly, or yearly replacement)
$50.00

New / Change from distance to Monovision Evaluation (one eye distance, one eye near vision)
$75.00

New / Changes to GP lens evaluation (Gas Perm to Soft Lenses; Soft Lenses to GP; Astigmatic)
$100.00 OR Mono/Toric

New / Change to Multifocal Lenses evaluation (soft or rigid)
$150.00

Keratoconus contact lens evaluation
$200.00

SYNERGEYES EVALUATION AND MATERIALS FEE

SynergEyes contact lens evaluation (rigid middle, soft skirt)

	Astigmatic $100	Premium $150	MultiFocal $150	Keratoconus $200
SynergEyes contact lens Materials:	**$350**	**$450**	**$450**	**$500**

(2 lenses per eye / 1 year)

Evaluation Fees include:

The initial evaluation of corneal health, corneal measurements (not Topography), fitting and evaluation of lenses, one pair of trial contact lenses (if applicable), instructions on handling contact lenses, and up to 3 follow up visits. The follow up visit is to be made approximately 1 week from the date you were initially fit with the trial contact lenses. You must keep this appointment. In accordance with Georgia law:

WE WILL NOT RELEASE YOUR CONTACT LENS PRESCRIPTION IF YOU HAVE NOT KEPT ALL FOLLOW UP APPOINTMENT(S), AS YOUR FITTING IS NOT COMPLETE.

You may reschedule a follow up appointment; however, you may incur additional fees for replacement of trial lenses. All contact lens fitting/evaluation fees are due **AT TIME OF SERVICE**.

By signing below, I have read and understand the information provided above for evaluation fees. I understand that these are NOT fees for the purchase of materials (contact lenses). I further understand that if my well vision plan does not pay in full for these services, I will be responsible for payment.

_____ _____ _____

Signature of Patient (or Guardian) Date **NEXT APPOINTMENT DATE**

ASK ABOUT OUR DISCOUNTS FOR A ONE YEAR SUPPLY OF CONTACT LENSES! Rev 2/2015