CONTACT LENS AGREEMENT

I am requesting a contact lens examination and fitting by Civano Eyecare. I will be able to ask any questions I have about policies and contact lenses prior to ordering my contact lenses. I give permission to Civano Eyecare to perform all the tests involved in a contact lens examination and fitting. In signing this form, I acknowledge that it is my responsibility to read all the printed contact lens educational materials provided to me. I understand that contact lenses have many benefits, but as with any other medical device or prescription drug, they are not without risks. A small percentage of wearers develop serious complications that can lead to permanent eye damage. I agree to follow ALL advice and instructions given to me by Dr. Finnell or contact lens technician.

I WILL REMOVE MY LENSES AND SEEK IMMEDIATE CARE IF I EXPERIENCE ANY UNEXPLAINED EYE PAIN, REDNESS, AND/OR VISION CHANGE.

_____	_____	_____
Patient Name	Patient Signature	Date

The contact lens fitting fees include all follow-up visits during the first 30 days. This is referred as the "trial period". Any office visits required after the trial period, will be charged a fee of $25.00 per visit. Every possible effort will be made to see that you are a good candidate for contact lenses, however, situations do arise that may preclude you from wearing them. THERE IS NO REFUND FOR PROFESSIONAL FEES, IF THAT IS THE CASE.

According to the State Board of Optometry rule R4-21-305, the contact lens prescription will be released by request only after completing a trial period appropriate under the circumstances for the lenses prescribed. IF YOU DO NOT SHOW UP FOR YOUR FOLLOW-UP VISITS, THE CONTACT LENS PRESCRIPTION CANNOT BE RELEASED.

_____	_____	_____
Patient Name	Patient Signature	Date