Central Ohio Vision and Eyecare

CONTACT LENS AGREEMENT

☐ I understand that contact lenses are medical devices and agree to abide by the wearing schedule set forth by the optometrist.

☐ I understand I must wear my lenses for at least two hours before coming in to evaluate the fit of said lenses.

☐ I understand that sleeping in contact lenses is dangerous and unsanitary.

☐ I understand that online rebates are my personal responsibility.

☐ Contact lens evaluation fees are non-refundable.

☐ Subsequent follow ups outside of 30 days will asses a Level 1 Contact Lens Evaluation fee ($40).

☐ I understand that diagnostic lenses are for evaluating fit.

I authorize Central Ohio Vision and Eyecare to perform a contact lens fit and evaluation so that I can wear contact lenses this year. I acknowledge that I will abide by the wearing schedule the doctor sets forth, that I should have a back up pair of glasses just in case I need them, and that it is my responsibility to make sure my contact lens prescription is finalized within 30 days and that the rules outlined above are followed as closely as possible. I understand and acknowledge that non-adherence to the above rules may invalidate my contact lens prescription for this year and require another fit and evaluation depending on the degree of non-compliance.

SIGNED: _____ DATE: _____