BECA CONTACT LENS AGREEMENT

We are delighted that you have given us the opportunity to serve your contact lens needs! Please note that contact lens services are based on your current eye examination which is billed separately. We recommend an eye examination every 12 months for optimum eye health with the use of contact lenses.

All contact lens fitting appointments are on a different day than the eye exam so that BECA can order appropriate trial lenses, based on your refraction and corneal measurements. There are two contact lens fitting plans offered at BECA: (Please check the plan that you prefer)

_____ **Package Plan** – This option includes trial lenses [one or more] until optimum fitting and vision are obtained. The time period extends 60 days from the day of fitting. Therefore, it is the patient's responsibility to return within that time frame for follow up, if any problems. At the end of successful fitting the patient will be given prescription for contact lenses and first supply of 2 boxes. Patient also has the option of buying additional lenses. **This plan is required for all new contact lens fitting patients.**

_____ **Non-Package Plan** – This option includes one pair of trial lenses, one time office visit - not billable to insurance, evaluation by Doctor, and written prescription given to patient to continue purchasing elsewhere and of course we are happy to fill your prescription at BECA. Recommended for patients who are satisfied with their current contact lenses.

Current contact lens information:
Right eye: _____
Left eye: _____
Place of last contact lens fitting: _____

We encourage patients to be familiar with their contact lens related insurance benefits. As a courtesy, we will verify contact lens benefit available through your insurance. Patient will be responsible for any balance remaining at the time of fitting appointment. Charges vary depending on different lenses BECA staff will discuss with you.

All charges and above options have been discussed to my satisfaction. I understand and agree to the above. Bill Insurance: YES_____ NO_____

Patient Signature: _____Date_____
Technician initial: _____