EnvisionSEE, LLC 206 Kings Highway East  
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**Contact Lens Evaluation**

Thank you for choosing EnvisionSEE, LLC for your contact lens needs. We take pride in providing the highest quality of contact lens care. Our doctor makes every effort to ensure that our contact lens prescriptions are individually tailored to each patient.

**What is a Contact Lens Evaluation?**

A contact lens evaluation is separate from a comprehensive examination and requires additional testing. Because a contact lens sits on the eye there are precise measurements that differ from a glasses prescription. The doctor takes into consideration many factors including ocular health, glasses prescription, and visual needs. For this reason, patients wearing contact lenses require more time and often more appointments.

**How Often Do You Need a Contact Lens Evaluation?**

Federal regulation requires contact lens prescriptions to expire after one year. Because the eye is a sensitive organ, it is susceptible to irritations and infections that may be caused by contact lens wear.

**What is Included?**

The contact lens evaluation covers a 90 day period of follow-up contact lens check appointments and a finalized contact lens prescription valid for 1 year from the start of the evaluation process.   
For first-time contact lens wearers\*, it will include a maximum of three 45 minute contact lens training appointments.

**How Much is a Contact Lens Evaluation?**

The contact lens evaluation fee will range in price depending on the complexity of the prescription and if you have worn contact lenses before.

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| --- | --- | --- |
|  | Established wearer | New wearer\* |
| Standard Fit (soft spherical) | $50 | $100 |
| Advanced Fit (soft toric/astigmatism, soft multifocal/monovision) | $75 | $125 |
| Medical Fit (RGP, Keratoconus) | $250 | $300 |

\*a new wearer is classified as someone who has never worn contact lenses, or will require a contact lens teach of insertion and removal of the lens

**I have read, understood, and agree to the terms above.**

Patient Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_