



Sound Vision Care, Inc.

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Southampton
1601 County Rd 39, Suite 5
(631)-283-0220 | (631)283-0299

Date: _____ Id: _____

Contact Lens Agreement

First time Contact Lens patients require the following:

- Contact Lens evaluation
- Contact Lens fitting
- Contact Lens training
- Contact Lenses
- 1 week Contact Lens check
- 1 year Comprehensive eye exam

Current Contact Lens patients require the following:

- Contact Lens evaluation
- Contact Lens fitting
- Contact Lenses
- 1 week Contact Lens check
- 1 year Comprehensive eye exam

Contact Lens evaluation & Contact Lens fitting:

Every year, each patient that wears Contact Lenses must be evaluated for any changes to their vision and their Contact Lens prescriptions. There is a fee each year dependent on your lens type and the measurement of your prescription. There are 3 levels of evaluation & fittings - Level 1, Level 2 and Level 3.

Contact Lens training:

Only applies to first time Contact Lens wearers and is to be completed to the satisfaction of the doctor. The fees for Contact Lines Training include 3 sessions for the patient to learn how to wear Contact Lenses.

Contact Lens follow up:

ALL Contact Lens follow ups are included within your Contact Lens evaluation/fit fees. The Contact lens follow up is at no extra charge if it is scheduled within a month and only necessary if the doctor recommends it.

***Fees: Contact Lens training: \$75**
(Includes 3 sessions)

Contact Lens Insurance:
\$25 per year insures that if there is any change of Prescription within the year – Any lenses purchased from Sound Vision Care, Inc may be exchanged for the new prescription. Boxes must be unopened.

Contact Lens evaluation/fit fee:

- Level 1: (Single Vision): \$80 _____
- Level 2: (Multifocal): \$110 _____ (Astigmatism/Monocular)
- Level 3: (RGP): \$150 _____ (Multifocal Astigmatism)

***ALL fees are due at the time of service and non-refundable.** If a patient is unable to complete the Contact Lens training on their first visit they have 2 more training sessions included in the training fee. If the patient is unable to master training they will not be able to continue to be a Contact Lens candidate until the doctor evaluates otherwise.

I have read, understood and agree to the terms above:

Patient Name: _____ Parent Name: _____ Date: _____
(Patients under 18)

Patient Signature: _____ Parent Signature: _____ Date: _____
(Patients under 18)