What is a Contact Lens Evaluation?

A contact lens evaluation is special (extra) testing for patients that currently wear contact lenses or are interested in wearing contacts. These tests are used to update your prescription and ensure your lenses are still the right fit.

Your contact lens prescription expires after 1 year and you will not be able to purchase contact lenses without a current prescription.

Unfortunately, insurance plans do **NOT** cover this test for elective contacts. If your lenses are deemed medically necessary, we will file to your **vision insurance** if we are contracted with your vision insurance, and you have medically necessary benefits. In addition to the $45 refraction fee, you will be charged the contact lens evaluation fee.

	Established Wearer*	New Fit or Refit**
Soft Standard	$65+	$105+
Soft Premium	$85+	$175+
Standard Gas Permeable	$125+	$225+

*Established wearer is someone that has been previously fit in the lens. There are no follow up appointments included. New patients must bring prior contact lens prescription to their appointment.
**New fit or refit is for patients that have never worn contact lenses or are changing the type of lens. The following is included in this fee: follow up care for 30 days as deemed necessary by the physician, trial contact lenses, and new wearer educational session.

Georgia Eye Associates recommends the following contact lens guidelines to help in the prevention of eye infections and potential loss of vision:

- **No Sleeping in Contact Lenses**
- **No Swimming/Showering in Contact Lenses**
- **Use Fresh Multipurpose/Disinfecting Solution Daily – Do NOT expose lenses to water**
- **Replace your contact lens case every 90 days**
- **Abide to the recommended wearing and cleaning schedules**

Please choose one of the following options below:

___ I have read this form and fully understand that I must have a refraction and contact lens evaluation today if I want an updated eyeglasses and/or contact lens prescription. I understand that I may be responsible for all or a portion of the refraction and contact lens evaluation fee.

___ I **opt out of having my prescriptions updated** and understand that I will not be able to purchase new eyeglasses and/or contact lenses without a current prescription.

Patient Name: _____

Patient Signature: _____ Date: _____