See Well Eyecare LLC
3330 Erie Avenue, Suite 14
Cincinnati, OH 45208
Phone: 513-268-8748
Fax: 513-268-8758
Website: https://seewellcincinnati.com/

Annual Contact Lens Evaluation & Informed Consent Agreement

Purpose

A comprehensive eye examination evaluates your eye health and vision. A separate contact lens evaluation is required to prescribe, fit, and monitor contact lenses.

The evaluation may include diagnostic lenses, corneal measurements, assessment of lens fit, vision, ocular health, insertion/removal training (when necessary), follow-up care, and finalization of your contact lens prescription.

Patient Responsibilities

Because contact lenses are FDA-regulated medical devices, I agree to:

• Wear contact lenses only as prescribed.

• Follow the wearing schedule, replacement schedule, and care instructions provided by the manufacturer unless my doctor instructs otherwise.

• If my doctor prescribes a different wearing schedule or replacement interval, I will follow my doctor's instructions.

• Wash and dry my hands before handling lenses.

• Use only approved contact lens care products.

• Never expose contact lenses to tap water, bottled water, distilled water, saliva, or homemade cleaning solutions.

• Replace my lens case regularly and use fresh disinfecting solution each time lenses are stored.

• Attend recommended follow-up appointments and annual contact lens evaluations.

Important Safety Information

Unless specifically prescribed by my doctor:

• I will not sleep in contact lenses.

• I will not wear contact lenses while showering, swimming, or during other water exposure.

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If I experience pain, redness, blurred vision, light sensitivity, discharge, injury, or sudden discomfort, I will immediately remove my contact lenses and contact See Well Eyecare.

Failure to seek prompt care may result in permanent vision loss.

Prescription Policy

I understand:

• A contact lens prescription is separate from a glasses prescription.

• My prescription will only be released after the fitting process is successfully completed and my doctor determines that my lenses fit safely and provide appropriate vision.

• Successful contact lens wear cannot be guaranteed for every patient.

• My doctor may discontinue contact lens wear or recommend another lens design if continued wear is not medically appropriate.

• Additional evaluations or refitting beyond the initial fitting period may require additional professional fees.

• Contact lens prescriptions generally expire one year from the examination date unless medically indicated otherwise.

Financial & Ordering Policies

Professional fees are separate from the cost of contact lenses.

Payment is due when services are rendered unless prior arrangements have been made.

Contact lenses will not be ordered or dispensed until the patient's financial responsibility has been satisfied.

Contact lens pricing is based on current manufacturer pricing, distributor costs, shipping expenses, rebates, and market conditions. Pricing may change without notice. Current pricing will be provided at the time an order is placed.

Manufacturer rebates, warranties, and promotions are subject to manufacturer terms and availability.

Special-order contact lenses cannot be canceled once submitted to the manufacturer.

Professional service fees are non-refundable once services have been rendered.

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Returns

Unopened, unexpired contact lens boxes may be returned in accordance with See Well Eyecare's current return policy and applicable manufacturer guidelines.

Opened boxes may only be exchanged if determined to be defective under the manufacturer's warranty.

Electronic Communication

Email, text messaging, voicemail, and the patient portal are intended only for routine, non-urgent communication.

Urgent symptoms—including sudden vision loss, severe eye pain, eye injury, flashes, new floaters, or significant redness—require immediate telephone contact with our office or emergency medical care.

Agreement Execution

Patient Acknowledgement

I acknowledge that:

• I have received an explanation of the contact lens evaluation process.

• I understand the risks associated with contact lens wear.

• I understand that safe contact lens wear depends upon following all prescribed wearing schedules, replacement schedules, care instructions, and follow-up recommendations.

• Failure to follow these recommendations may result in serious eye complications, permanent vision loss, and may affect manufacturer warranties or replacement eligibility.

• I authorize See Well Eyecare to provide the professional services necessary for my contact lens evaluation and management.

Nothing in this agreement limits rights provided under applicable federal or Ohio law.

Staff Review Checklist

☐ Wear schedule reviewed

☐ Replacement schedule reviewed

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☐ Cleaning and disinfection reviewed
☐ Water exposure discussed
☐ Sleeping in lenses discussed (if applicable)
☐ Warning signs reviewed
☐ Annual evaluation requirement discussed
☐ Patient questions answered

Patient

Printed Name _____

Signature _____

Date _____

See Well Eyecare

Team Member _____

Signature _____

Date _____