

Contact Lens Fitting Consent Form

Thank you for choosing **Watts Eye Associates LLC** for your Contact Lens care. Our mission is to ensure the health of your eyes with all your Contact Lens needs.

Please read our contact lens exam policies, sign and date the bottom. By signing, you agree with our contact lens policies and agree to pay for in full any contact lens related fees.

- **CONTACT LENS FITTING:** The fitting fees are as follows:

a) Level 1 - Spherical	\$145
b) Level 2 – Astigmatic/Bifocal/Extended Wear	\$195
c) Level 3 – Specialty/Custom	\$265

These fees cover the initial fitting process and follow up visits for up to 3 months as well as all insertion and removal training times. Fitting fees are due at your initial fitting appointment.
- **CUSTOM CONTACT LENSES:** All custom contact lens orders require a deposit of 50% before we can order the lenses. When we finalize the prescription, the remaining balance is due.
- **CONTACT LENS ANNUAL FEE:** After your initial fitting, you will have Semi-Annual and Annual eye health exams to maintain your contact lens prescription. The contact lens portion of your exam is not covered by your regular health insurance. Contacts are deemed cosmetic and not medically necessary. This fee covers the cost of the extra testing required to update your contact lens prescription. This fee is \$48.00 for a Level 1 Annual and \$60.00 for a Level 2/3 Annual. for each annual and semi-annual visit. If you purchase a year supply of contacts, we will waive the semi-annual fee.
- **CONTACT LENS PRESCRIPTION:** Your prescription is valid for one year from date of Contact Lens Annual/Final Fitting follow up. Contact Lens prescriptions are not the same as glasses prescriptions. This **Federal Guideline** is managed by The Fairness to Contact Lens Act ([Pub.L. 108-164](#), 117 [Stat.](#) 2025, 2026, 2027, 2028 and 2029, [codified](#) at [15 U.S.C. ch.102 et seq.](#)), also known as FCLCA)
- **All fitting fees** and open balances must be paid before we will release your prescription.
- **CONTACT LENS ORDERING:** We work with a carrier service that delivers most prescriptions overnight to us. Please call our office or go on-line at www.wattseye.com to order your contacts. We offer direct mail on most brands of our contact lenses at no additional charge for an annual supply. Custom contact lenses can take a few days or weeks to be manufactured. We will be glad to update you on the progress of the lenses if you would like. Please ask an associate for details on your contacts and any rebate offers.

Our staff will be happy to explain this process in further detail if you wish. We understand that fees can sometimes be confusing and we are hoping to make this process as simple as possible. Thank you.

Print Patient Name:

Sign Name:

Date _____ (Parent if under 18yrs.)

Contact Lens Annual Consent Form

Thank you for choosing **Watts Eye Associates LLC** for your Contact Lens care. Our mission is to ensure the health of your eyes with all your Contact Lens needs.

Please read our contact lens exam policies, sign and date the bottom. By signing, you agree with our contact lens policies and agree to pay for in full any contact lens related fees.

- **CONTACT LENS ANNUAL FEE:** The contact lens portion of your exam is not covered by your regular health insurance. Contacts are deemed cosmetic and not medically necessary. This fee covers the cost of the extra testing required to update you contact lens prescription. The fees are as follows
 - a) Level 1 – **Spherical** \$48
 - b) Level 2 – **Astigmatism/Multifocal/ Specialty** \$60
- **CONTACT LENS PRESCRIPTION:** Your prescription is valid for one year from date of Contact Lens Annual. Contact Lens prescriptions are not the same as glasses prescriptions. This **Federal Guideline** is managed by The Fairness to Contact Lens Act ([Pub.L. 108-164](#), 117 [Stat.](#) 2025, 2026, 2027, 2028 and 2029, [codified](#) at [15 U.S.C. ch.102 et seq.](#)), also known as **FCLCA**)
- **CONTACT LENS RE-FITS:** If you contact lens needs change requiring being fit into a new type of contact lens, a fitting fee will apply. Needs to be re-fit may be eye health issues, poor vision, or poor comfort with current contact lenses. The re-fit fees are as follows:
 - a) Level 1 - **Spherical** \$95
 - b) Level 2 – **Astigmatism/Multifocal** \$145
 - c) Level 3 - **Specialty** \$215These fees cover the initial re-fit process and follow up visits for up to 3 months.
If the reason for a re-fit is eye health related and you refuse, the doctor has the right and obligation to refuse renewal of your Contact Lens prescription.
- **CONTACT LENS ORDERING:** We do carry some contact lenses in stock. Please call for any contact lens order. We also have contact lens ordering available on-line at www.wattseye.com. We offer direct mail at no additional charge to annual supply of contact lenses. Some custom made contact lenses will require additional visits either with the doctor or staff. Please ask staff member for details on your contacts and any rebate offers.

Our staff will be happy to explain this process in further detail if you wish. We understand that fees can sometimes be confusing and we are hoping to make this process as simple as possible. Thank you.

Sign Name _____ Print Name: _____
(Parent if under 18yrs.) Date: _____

INSURANCE INFORMATION

Dear Patient:

Thank you for choosing **Watts Eye Associates!** Our mission is to deliver the highest quality of eye care you will ever receive. As a courtesy, Watts Eye Associates will be happy to bill your insurance company for your visit with us. Please understand that this is your insurance policy, not ours. Please read our insurance policies, sign and date the bottom. By signing, you agree to pay your claim if for any reason your insurance company denies it.

- **INSURANCE CARDS:** Please have your card with you so we can copy all the necessary information. This will make the billing process easier for all of us. If your insurance should change in the future, please inform the office prior to your next visit.
- **CO-PAYS:** Have your payment ready when checking in at the front desk. This is a contractual obligation with you insurance company for which you are responsible and it is mandatory that we collect it from you.
- **REFERRALS:** As a member of an HMO, you have become a partner with your Primary Care Physician and it is mandatory that you get a referral from your Primary Care Physician to see a specialist. Optometrists are considered specialists. We require referrals for all visits that are not routine in nature, i.e. itchy red eyes, an injury to your eye(s), seeing light flashes or floaters, and so on. If possible, obtain multiple visits in your referral so you do not have to repeat this process if we need to see you more than once. If a referral has not been obtained and the claim is denied, you will be responsible for payment in full.
- **INSURANCE BENEFITS:** There are many insurance companies and many plans within insurance companies. Therefore, it is in your best interest to verify your benefits. Know your deductible amounts and confirm that Dr. W. F. Watts or Dr. C. E. McDonald is listed on your insurance companies provider list. Please also verify that you do not need a prior authorization for your visit. **Many Vision programs do not issue their own insurance cards so it is crucial that you are aware of your Vision Program prior to your visit as your health insurance card will not inform us of separate vision programs.**
- **WORKER'S COMP:** We do not bill Worker's Comp. cases. Payment is expected in full at the time of the visit. We will be happy to assist you in any paperwork or forms that need to be filed.
- **SELF-PAY:** Payment is made in full at the time of the visit.
- **CONTACT LENS FITTINGS:** If you elect to try contact lenses, a separate fitting exam must be performed. This is a non-billable visit and must be paid for at the time of service. The fitting fee includes the initial fitting visit; training time, sample solution and trial lenses, and all follow up visits for the first three months. This fee is non-refundable. These fees do not include your contact lenses. We can exchange any unopened boxes of contacts that are not expired.
- **FRAMES, LENSES, and YOUR PRESCRIPTION:** All of our frames have a warranty ranging from 6 to 12 months, and our lenses with a scratch resistant coating have a 12 to 24 month warranty on normal wear and tear. Please ask for more details on other warranties and policies.

Our staff will be happy to assist you through any of the processes listed above. We understand that insurance policies and programs can be quite confusing. Your patience and understanding will be greatly appreciated in helping to resolve any problems.

Signature _____

Print Name:

RETINA HEALTH INFORMED CONSENT

Drs. McDonald and Watts use today's most advanced technologies to provide patients with the most thorough eye health evaluations possible. These technologies are called the OPTOMAP and OPTICAL COHERENCE TOMOGRAPHY (OCT). Both technologies provide very detailed digital images of your Optic Nerve, Macula and Retina in both 2D and 3D views. The combination of both images will allow us to detect certain eye health problems at the earliest stages, often 1-2 years before a patient would be aware something was wrong with their vision. Detecting potentially blinding diseases in the earliest possible stages always provides the best chance for preventing permanent vision loss.

With the OPTOMAP and OCT we will be able to more accurately and efficiently evaluate you for:

- Macula Degeneration
- Glaucoma
- Retina Detachments
- Retina Melanomas and other eye cancers
- Diabetic Eye Disease
- Complications from High Blood Pressure
- Optic Nerve Diseases
- Complications from High Cholesterol

Both the OPTOMAP and OCT are quick camera flashes that take seconds. Best of all, it may eliminate your need for dilating eye drops at today's visit. We strongly recommend all patients have the images taken at each year's exam, providing the most thorough eye health evaluation available.

Both technologies are covered by most major health insurance plans if we detect one of the above conditions. If we are unable to bill your insurance for the OPTOMAP and OCT images, the combined fee for both is **\$48**

Signature and Date/

PEDIATRIC RETINA HEALTH INFORMED CONSENT

Drs. McDonald and Watts use today's most advanced technology to provide young patients with the most thorough and patient friendly eye health evaluations possible. This technology is called the OPTOMAP. The technology provides very detailed digital images of the Optic Nerve, Macula and Retina. The OPTOMAP images will allow us to detect certain eye health problems at the earliest stages, often before a person would be aware something was wrong with their vision. Detecting potentially blinding diseases in the earliest possible stages always provides the best chance for preventing permanent vision loss.

With the OPTOMAP we will be able to more accurately and efficiently evaluate your children for:

- Pediatric Eye Cancers
- Pediatric Glaucoma
- Retina Detachments
- Genetic Retina Diseases
- Diabetic Eye Disease
- Optic Nerve Diseases

The OPTOMAP is a quick camera flash that takes seconds. Best of all, it may eliminate your child's need for dilating eye drops at today's visit. We strongly recommend all children have the images taken at each year's exam, providing the most thorough eye health evaluation available.

The OPTOMAP technology is covered by most major health insurance plans if we detect one of the above eye health conditions. If we are unable to bill your insurance for the OPTOMAP, the image fee is **\$37**

Signature and Date

Acknowledgement of Receipt

I acknowledge that I have been informed of the Health Insurance Portability and Accountability Act (HIPPA/HIPAA)

Name of patient:

Signature: _____

OR

I acknowledge that I have been informed of the Health Insurance Portability and Accountability Act (HIPPA/HIPAA)

I release my information to my immediate family members i.e. Mother, Father, Spouse Adult Children.

Name of patient:

Signature: _____

OR

I acknowledge that I have been informed of the Health Insurance Portability and Accountability Act (HIPPA/HIPAA)

I release my information to my Caretaker :

Name of patient:

Signature: _____