Contact Lens Agreement Form

Name: ____

Date of Birth: _____________

In consideration of the fitting and supplying of contact lenses by **Cambridge Optometry**, I, the undersigned, agree to the following terms and conditions:

1. **Contact Lens Fitting and Examination:** I understand that the evaluation and fitting of contact lenses require additional procedures beyond a routine eye examination. I agree to undergo these additional procedures as recommended by the optometrist.
2. **Financial Responsibility:** I understand that contact lens evaluation, fitting, and related services may not be covered by my insurance plan and that I am responsible for all associated fees and costs. Fees range from **$33 to $275***, depending on the complexity of the evaluation and/or fitting. Please ask if you have questions regarding fees for your specific contact lens situation.
3. **Proper Lens Wear and Care:** I understand the importance of proper lens wear and care, including cleaning, disinfection, and storage. I agree to follow the instructions provided by the optometrist and the contact lens manufacturer for the safe and effective use of contact lenses.
4. **Scheduled Follow-Up Visits:** I agree to attend all scheduled follow-up visits as recommended by the optometrist to monitor the fit, comfort, and ocular health of the contact lenses.
5. **Adverse Reactions and Complications:** I understand that contact lenses are medical devices and may cause adverse reactions or complications, including but not limited to discomfort, dryness, redness, infection, and corneal ulcers. I agree to promptly contact Cambridge Optometry if I experience any such symptoms.
6. **Replacement and Renewal:** I understand that contact lenses have a limited lifespan and need to be replaced regularly according to the recommended wearing schedule. I agree to follow the recommended replacement schedule and renew my contact lens prescription as required by law.
7. **Agreement to Release Liability:** I release Cambridge Optometry, its doctors, staff, and affiliates from any liability for any damages, injuries, or losses arising from the use of contact lenses, including but not limited to negligence, errors, or omissions.

I have read and understood the above terms and conditions, and I agree to comply with them to the best of my ability.

Patient Signature: ____ Date: _______________

Parent/Legal Guardian Signature (if a minor): __________________________________ Date: ____________

(* Fees for Scleral fittings can exceed this price range.)