Agreement and Contract for Laser Vision Correction

Name: ___________________________________

Contact Lenses: Discontinue wear of soft contact lenses at least 24 hours prior to examination and surgery unless otherwise specified. Gas permeable lenses should be removed at least 2 weeks prior to laser eye care unless otherwise specified. Hard contacts may need to be discontinued for a longer period due to the possibility that they may cause corneal warpage.

Covered Period: All necessary and appropriate aftercare pertaining to laser vision correction for a period of _____ months after the date of surgery is included in the surgery fee. If any care is requested after the covered period, fees may be due.

Follow-up care will be provided by:

[ ] This office or

[ ]Your optometrist, Dr.________________________. If you choose to see your optometrist, our office is available should any questions or problems arise.

Payment: Due at time of surgery is $________ per eye or $____________ for both eyes. Payment may be made by cash, credit card (we accept Visa, MasterCard,), or check. Payment by personal check must be made no later than 5 business days prior to scheduled surgery. Cashier's checks are the only checks acceptable if within this 5-business-day period.

Enhancement: A small percentage of the time, after laser vision correction, an 'enhancement' or 'touch-up' surgery can improve vision clarity. Costs for enhancement care after the covered period may vary depending upon when service is requested and upon the interval since initial surgery.

Cancellation Policy: We provide certain professional services as a part of our consultation, which is done at no charge. Once you have done the pre-operative step of a dilated exam and for any reason you choose to completely cancel surgery that has been scheduled, our office will charge a $300 cancellation fee. If you fail to notify our office within 24 hours of your scheduled surgery date an additional $200 charge will be assessed.

Unrelated Care: If you develop an eye problem unrelated to laser vision correction during the aftercare period, care for this condition may incur a separate charge for which you will be responsible. Care for medical problems of the eyes (such as infection, allergy, and injury) may be covered by your health insurance (if applicable) but you will still be responsible for payment. Signature at the bottom of this form authorizes our office to bill your insurance carrier and collect for medical treatment rendered as necessary and appropriate, should this arise. We will not ask you for your health insurance information unless and until such care is rendered.

I hereby request vision correction care for my [ ] Right Eye [ ]Left Eye [ ]Both Eyes

_____________________________________ Patient Signature

_____________________ Date

_____________________________________ Surgery Counselor

_____________________ Date