THE PURPOSE OF THIS FORM IS TO HELP YOU MAKE AN INFORMED CHOICE ABOUT WHETHER OR NOT YOU WANT TO RECEIVE THESE ITEMS OR SERVICES, KNOWING THAT YOU MIGHT HAVE TO PAY FOR THEM YOURSELF. BEFORE YOU MAKE A DECISION ABOUT YOUR OPTIONS, YOU SHOULD **READ THIS ENTIRE NOTICE CAREFULLY.**

 THESE ITEMS OR SERVICES WILL COST YOU (ESTIMATED COST $\_\_\_\_\_\_\_\_\_)

* NEW CONTACT FITTING FEE $150.00
* CONTACT FORM $65.00
* REFRACTION $35.00

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

 **Option 1. YES I want to receive these items or services.**

*I UNDERSTAND THAT MY INSURANCE(S) WILL NOT PAY IF I CHOOSE TO RECEIVEA NEW PRESCRIPTION FOR GLASSESOR CONTACT LENS. I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.*

 **Option 2. NO I have decided not to receive these items or services.**

*I WILL NOT RECEIVE THESE ITEMS OR SERVICES. I UNDERSTAND THAT I WILL NOT RECEIVE ANY SERVICES FOR A NEW PRECRIPTION FOR GLASSES OR CONTACT LENS.*

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Date of Service **Print** patient’s name or person acting on patient’s behalf

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed **Signature** of patient or person acting on patient’s behalf