Name:

DOB:

MRN:

Contact Lens Pricing Guide

Contact lens fittings are a separate service from your regular eye examinations and there are separate fees that apply. For current contact wearers, please bring your current contact lens prescription and/or current contact lens box.

Most medical insurance plans do not cover contact lenses and we do not participate with vision plans. If you have insurance coverage for contact lenses, you can request to be reimbursed by your insurance company but are responsible for the full charge of the exam due at the time of service. The type of lens will be determined on the day of your fitting.

Fitting Fees (Due on the day of fitting and are non-refundable)

Type of Fitting	Spherical Lens	Toric Lens	What's Included
New Patient Not Previous Contact Lens Use Evaluation Exam	$150	$175	Evaluation Exam Follow up visits for 60 days. Trial Lenses (annual supply not included) Contact Lens Training
New Patient with Previous Contact Lens Use Evaluation Exam	$100	$100	Evaluation Exam Follow up visits for 30 days. Trial Lenses (annual supply not included)
Established Patient Annual Contact Lens Maintenance Exam	$50	$50	Maintenance Exam No follow up visits included. Trial Lenses (annual supply not included)
Incomplete Fitting Exam – initiated but not completed	$40	$40	No follow up visits included

Contact Lens Fees

- Contact lenses are purchased separately. If you wish, they can be ordered in Connecticut Children's in-house optical shop and shipped to your home.
- Contact lenses must be paid in full at the time of ordering.

Contact Lens Prescription

- You will be provided with a copy of your contact lens prescription once the fitting process has concluded. Contact lens prescriptions are valid for one year in the State of Connecticut.

I want the services listed above for me/my child. I understand that I will be asked to pay now for the services listed above, and my medical insurance will not be billed by Connecticut Children's.

Name of Patient/Legal Guardian (Print Name): _____

Relationship to Patient: _____

Signature of Patient/Legal Guardian: _____ Date: _____