ZDENEK EYE INSTITUTE and Laser Center

Contact Lens

Name:_____ **Date**: _____

Insurance: _____ _____
Medical Insurance Vision Insurance

Refraction Coverage: ❑ Yes ❑ No

Current Contact Lens Information:

_____ _____ _____ _____
Brand (ex. Acuvue Oasys, Air Optix) Size (ex. 8.4) Power: Right Eye Left Eye

If you have had a contact lens exam with Dr. Zdenek within the last 2 years then you will receive a $100 discount on your Exam today. Ask one of our staff members if you qualify for a discount.

Please select what type of exam you would like during your visit today.

❑ **Contact lens Exam** **$225**
To check to health of your cornea, measurements to determine shape of the eye, test to determine lens power and correct fit of contact lenses

❑ **Eye glass Exam** **$60**
Test to determine the prescription of glasses

❑ **Contact lens + Eye Glass Exam $250**

Your medical insurance will not be billed with the above selection. If you would like a Complete Eye Exam, ask a staff member if your insurance covers a Complete Eye Exam.

I understand that I will be charged the above pricing based on my selection. Payment is due at the time services are rendered.

_____ _____
Signature Date