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**www.sigeyecare.com**

**(512) 250-1700**

**Contact Lens Compliance Agreement**

I am a first time contact lens wearer. I have received a training form and instructions on how to properly insert, remove, and handle contact lenses.

I have worn contact lenses previously. I am fully aware of the insertion, removal, and handling techniques of contact lenses.

I understand that the contact lens evaluation is an additional option to my routine eye exam and may not be fully covered by my insurance plan. A contact lens is a medical device that requires additional annual testing. The fee for a contact lens evaluation will be determined by the type of contact lens that is required for my prescription.

I agree to follow the instructions given to me by this sheet, the doctor, and the dispensing staff. I understand that my cleaning and wearing schedules are very important in maintaining my contact lenses and the health of my eyes. I understand that improper use of my contacts can lead to permanent vision loss. I also understand that by wearing contacts I am increasing my risk for eye infections, allergies, and other eye complications, that can lead to blindness or vision loss.

I am to remove my contacts immediately and call my eye doctor if:

1) Unusual burning, irritation, redness, pain, or watering of the eyes occurs

2) I suspect something is wrong

3) Unusual blurred vision

Wear schedule for ***first time wearers*** in

My Contacts are: 2 week and monthly lenses:

To be removed every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be disposed every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be cleaned and rubbed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day 4 & Beyond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I understand and agree to all the terms outlined on this form. I also have received a copy of this form for my reference.**

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Signature of Patient, Parent/Guardian Patient’s Printed Name

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Initials of Signature Eye Care Staff Date