Washington Pacific Eye Associates
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CONTACT LENS EVALUATION POLICY

In 1994, the State of Washington passed the Vision Care Consumer Assistance Act, changing State regulations for contact lens prescriptions. This notice is to help clarify the regulations.

During your visit with Washington Pacific Eye Associates you may choose to have the physician perform an evaluation to prescribe contact lenses. The contact lens evaluation is not part of your routine eye exam and most insurance companies do not cover the cost of contact lens services.

To prescribe contact lenses, additional testing must be completed to evaluate the effect contact lenses have on your overall eye health. The contact lens prescription is not valid until you have seen a physician with the prescribed contacts on and the contact lens evaluation is deemed complete by the physician (Washington State Law RCW 181.95).

In the event the contact lens prescription needs to be modified, Washington Pacific Eye Associates provides two additional follow up appointments within 90 days of the initial evaluation at no additional cost. Contact Lens services outside of the two additional follow-ups or 90 days will incur another contact lens evaluation fee.

Contact lens evaluation fees are not refundable. The cost of contact lens materials are not included in the evaluation.

Contact Lens Evaluation Fees:

New Spherical: $95.00	New Multifocal: $120.00	New RGP: $170.00
Established Spherical: $65.00	Established Multifocal: $85.00	Established RGP: $120.00

If you choose to have your contact lenses prescribed elsewhere, you will receive a glasses prescription following your routine eye exam with the notation "OK for Contacts" per the Vision Care Consumer Assistance Act.

I have read the Contact Lens Evaluation Policy above as outlined by Washington Pacific Eye Associates.

☐ Yes, I would like to have a contact lens evaluation.

☐ No, I do not want to have a contact lens evaluation. I understand I cannot order contacts without a valid contact lens prescription.

____ Date:_______________

Patient Signature (or patient representative if under 18)

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Patient Name (please print)