Kapolei
EYE CARE

Nancy Chen, M.D
Peony Tam, O.D.
511 Manawai St, Unit 401, Kapolei, HI 96707
Ph: (808) 674-CARE [2273] · Fax: (808) 674-2552
CONTACT LENS CONSENT FORM

_____
(Print Patient Name)

This consent is to make you aware of our policies regarding the fit of contact lenses.
1. To purchase contact lenses, no matter if it is a yearly renewal or a first time fitting, a contact lens fit is required by law.
2. Kapolei Eye Care policy also states that payment **IS REQUIRED** on the same day of the fitting.
3. A contact lens fitting is not covered by most insurance, because it is considered to be **cosmetic**. (You will be responsible for the fitting fee that can vary from $50 to $130 depending on your eyes' needs).
4. Upon examination, should Dr. Chen or Dr. Tam find a medical condition, she may bill your **Medical** insurance for your visit.

If you decide to purchase your contact lenses with our office, please note that **BEFORE** any contact lens orders can be placed, you must:
1. Have NO outstanding balance(s) on your account.
2. Pay in full for your portion of your order. If we are billing your insurance(s), then you will give us the right to send you a statement for the amount due that is not covered by your insurance(s) for the reason(s) specified by your insurance(s). **Please make sure we have ALL your insurance info. Please check with our staff what current insurance information we have on file.
3. You must pick up your order within 3 months from the date the order was received in our office. Failure to do so will result in a $20 restock/return fee to send back orders to the manufacturer(s). If an order is placed and received by our office, but canceled by you, the $20 restock/return fee also applies. ***Please make sure we have current phone numbers to reach you. Check with our staff to see what phone numbers we currently have on file.

By signing below, I, _____, understand the above policies of Kapolei Eye Care.   (PRINT NAME)

Signature of Patient or Legal Guardian _____ **Date** _____