Vista Eye Care

Custom Contact Lens Policy

Vista Eye Care prides its self in our ability to assist patients needing custom contact lenses. Custom contact lenses can provide excellent vision that may not be achievable by other means. Your lenses are ordered through our trusted laboratories to meet the unique specifications of your own eyes and vision, and because your contact lenses are custom made, we have no ability to return those lenses to the manufacturer. We will do everything we can to assure that you are successful with your contact lenses, though before we order your lenses, you must agree to our Custom Contact Lens Policy:

- Custom Contact Lens parameters can be adjusted during a 30-day Initial Lens Wear Period from the time of initial dispense. We recommend patients with Custom Contact Lenses return for a follow-up during that 30-day period to make sure no changes need to be made to the lenses.
- Custom Contact Lenses need to be paid for in full before you leave the office with them. If we are billing a medical insurance or vision plan for your lenses, your portion of the lenses must be paid before you leave the office with the lenses.
- Custom Contact Lenses cannot be returned for a refund. If you need to switch to another lens type, you are welcomed to a credit towards your new lens type within the 30-day Initial Lens Wear Period.
- The Contact Lens Evaluation and Fitting Fees are for the service of having contact lenses assessed and the patient trained on their insertion and removal.
- Vista Eye Care does not charge additional fees to switch lens type and does not charge for follow-ups, however, the Contact Lens Evaluation and Fitting Fee is not refundable.
- We will do everything we can to bill your lenses and/or fit/evaluation fees to the insurance or vision plan of your choice, though you are ultimately responsible if your insurance doesn't cover your exams or materials.
- Custom Contact lenses carry no warranty.

Please sign here that you understand and agree to our Custom Contact Lens Policy:

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Evaluation / Fitting Fee: Estimated Lens Cost:

_____ _____

Patient Name (Printed): Patient Signature:

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Date: