

# OVERNIGHT SIGHT PRICING POLICY FOR YEAR TWO AND BEYOND

## **Annual renewal fee for continuing *Overnight Sight* patients: \$350**

Includes annual evaluation, 6-month evaluation, and any other follow-up evaluations as needed. It also includes (1) one in-office laboratory cleaning for molds if needed. It does **not** include leasing replacement corneal molds. **This fee is not covered by vision or medical insurance.** Annual comprehensive eye examinations are always required and are **not** included in this fee. Cary Family Eye Care reserves the right to change these fees at any time.

**Replacement Corneal Molds:** Corneal molds are typically replaced every 12 months. In some cases, corneal molds will not last 12 months, and occasionally a pair of molds will last a bit longer. Also, sometimes changes in a patient's corneal curvature or diameter will necessitate a change in the parameters of the corneal molds before they are a year old. While corneal molds are included in the evaluation fees for year one, they are not included for year two and after. The cost of corneal molds ranges from \$210.00 to \$230.00 per mold per year. **If the patient is overdue for annual renewal by more than 3 months, the renewal fee *may* increase to \$450.** In some cases, contact lens material benefits offered through vision insurance may cover a portion of the molds.

## **Please initial to indicate your understanding of the Overnight Sight Program**

\_\_\_\_\_ I understand the pricing policy for my Overnight Sight Therapy program.

\_\_\_\_\_ I understand that Overnight Sight annual program fees are not covered under my vision or medical insurance.

\_\_\_\_\_ I understand that Cary Family Eye Care will not bill my vision plan and will not assist me in submitting insurance claims for Overnight Sight annual program fees.

\_\_\_\_\_ I understand that continued monitoring during this program is needed to ensure corneal health and optimal vision, and I agree to keep scheduled appointments with Cary Family Eye Care.

**My signature below indicates my understanding and acceptance of these policies.**

Signature of patient (or parent if minor): \_\_\_\_\_ Date:

