MORRIS NEEL, O.D.

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CONTACT LENS INFORMED CONSENT

Contact lenses are a medical device and have both benefits and risks. A small percentage of contact lens wears may develop such complications as infections or corneal ulcers, which can lead to permanent damage in vision loss. The risk of complication increases with the length of time the contact lenses are worn each day and the age and condition of the lenses. These risks are greater when the lenses are worn overnight and with older deposit-coated lenses.***Therefore, we do not recommend sleeping in lenses.** Compliance with the recommended lens care system and regular contact lens checkups will reduce the risk of complications.

As a contact lens patient I have been instructed in the proper care and handling of my contact lenses. I understand the importance of following these instructions exactly and I understand the importance of returning for regular contact lens checkup at least once a year, or more if advised by my doctor.

***I agree to follow recommended wearing schedule and care procedures and to keep scheduled appointments.** I will notify the doctor immediately if any eye or vision problem, such as redness, eye pain or decrease in vision occurs.

I have been fully informed of the benefits and risks of contact lens wear. I have also been informed of the possible risks, consequences, and side effects of contact lens wear. I understand that I may not be able to successfully wear contact lenses. I will be able to ask any questions concerning the doctor's policies and contact lenses prior to the purchase of contact lenses.

***In order to guarantee insurance benefits, contact lenses must be finalized within *30 days*. I understand I have *30 days* to complete the fitting process otherwise additional fees may apply.** I have read this consent form, I understand and agree to abide by the instructions and recommendations contained herein.

Patient Name Print	Patient Name Signature
	Parent or Guardian (required if patient is under 18)
Technician	Date