CORNEAL REFRACTIVE THERAPY AGREEMENT

We welcome you into our Corneal Refractive Therapy (CRT) treatment program. You are beginning an exciting program designed to reduce and/or eliminate your dependency on eyeglasses or contact lenses during the day by reducing or eliminating your myopia (nearsightedness).

Paragon CRT® therapeutic lenses will gently and non-surgically reshape your corneas as you sleep.

DURATION OF TREATMENT

The length of your treatment will be primarily determined by your prescription, and your compliance with the prescribed CRT wearing schedule. Typically, we expect to see 90% of the vision changes within the first week of treatment and full treatment within two weeks. Some eyes will require a longer period of time to complete the process. Thereafter, the lenses will have to be worn routinely to maintain treatment vision.

PROFESSIONAL FEES

The fee for CRT includes all professional services and all Paragon CRT therapeutic lenses that are required to complete the treatment, for a period not to exceed (12) twelve months.

Your Corneal Refractive Therapy treatment will begin on _____, and will conclude on_____.

The following fee is includes all the office visits and treatment lenses necessary during the above treatment period.

The total fee for services related to your Corneal Refractive Therapy treatment, including all treatment lenses prescribed is $999.00.

This fee must be paid before your Paragon CRT therapeutic lenses are dispensed. Our office also offers a convenient patient financing program through CareCredit.

SPARE PAIR

We recommend that you always have a spare pair of lenses. Treatment may be compromised if disrupted by discontinued wear due to lost or damaged lenses

A spare pair can be ordered within 90 days of successful treatment. A spare pair of Paragon CRT lenses can be ordered for $180.00.

Subsequent Paragon CRT lenses (if needed) will be replaced at a cost of $120 each.

DISCONTINUATION OF CRT

It is a rare occurrence in health care that any procedure succeeds in every case. Should either you (the patient) or Dr. _____ decide to discontinue treatment within the first 6 months of this agreement, then the amount of your refund will be $500 after return of contact lenses.

PATIENT RESPONSIBILITIES

1. Follow all verbal and written instructions.
2. Attend all scheduled appointments.
3. Use only the prescribed lens care system.
4. Comply with the prescribed wearing schedule for the lenses.
5. Report all treatment related emergencies immediately by calling the emergency numbers provided.

PROVIDER RESPONSIBILITIES:

1. Provide clear verbal and written instructions.
2. Provide reasonably convenient office hours for all prescribed visits.
3. Assure the quality of the services and materials provided.
4. Respond to all reported treatment related emergencies in a timely manner.

INFORMED CONSENT

___ I understand that this procedure is designed to change my vision through corneal reshaping.

___ I understand that I will experience altered vision through my current eyeglasses and/or contact lenses due to the change corneal curvature a result of Corneal Refractive Therapy. There is no guarantee that my uncorrected vision will improve following Corneal Refractive Therapy.

___ I understand and agree to seek immediate care by calling 717-266-5661 during regular hours or _____ after hours, should I notice excessive pain or excessive redness.

TREATMENT PLAN ACCEPTANCE

I have read and understand the above, and I am in complete agreement with the contents of this agreement. The undersigned hereby agree to the terms of this agreement and agrees to perform their responsibilities in an effort to achieve optimum success in the Corneal Refractive Therapy treatment.

_____
Patient Name

_____ _____
Signature of Patient (Parent or Guardian) Date

_____ _____
Witness Date

WE APPRECIATE THE CONFIDENCE AND TRUST YOU PLACE IN US FOR YOUR CORNEAL REFRACTIVE THERAPY.