

Patient Informed Consent for Contact Lenses

By signing this Patient Informed Consent form, I certify that I have read the Contact Lens Information sheet and understand and accept the risks and possible consequences associated with contact lens usage. In addition, my optometrist has explained the benefits and risks of contact lenses, as well as proper lens care, and all of my questions have been sufficiently answered. I hereby agree to follow the contact lens care and maintenance instructions provided by my optometrist.

I understand the importance of adhering to the contact-wearing schedule discussed with my optometrist, and realize that it is my responsibility to maintain necessary follow-up examinations, and to contact my optometrist if adverse effects do occur. I understand the importance of having a backup pair of glasses with my updated prescription in case something happens to my contact lenses.

If I fail to comply with proper contact lens protocol, such as follow-up examinations and adequate lens care, I realize that it is within my optometrist's right to withhold my lens prescription.

I know that it is within my rights to discontinue contact lens wear for any reason at any time, and acknowledge that at this time my decision to wear contact lenses has been voluntarily made. As such, i2iOptometry is not held liable for any complications that may occur.

Patient's Name

Patient's Signature

Date

*(Parent/Legal Guardian if Patient
is under 18 years of age)*