

MiSight Myopia Management Program

Patient Name: _____ **DOB:** _____

The MiSight Myopia Therapy Program is **12 months** in length and is \$1800.

This fee includes:

- Evaluation and consultation
- Diagnostic testing performed for Myopia Management
- All follow-up appointments for 12 months
- Year supply of FDA-approved MiSight 1 Day contact lenses for myopia control

The Program does NOT include:

- A comprehensive eye exam. This must be current within 1 year to be eligible for the program.
- The cost of contact lens evaluation if performed.
- The material costs of glasses

Year 2 and Beyond: We offer an MiSight Myopia Therapy Program maintenance which includes all follow-up appointments, year supply of contacts and diagnostic testing performed for myopia management. This continued care is \$1600 for every 12 months of coverage.

Guarantee:

If circumstances prevent you from continuing your treatment during the first month of signing this agreement, Metro Eyes will provide a 50% refund.

This program outline is true and correct until _____; after this time, the data collected becomes outdated and an additional consultation is needed.

I, undersigned, fully understand the MiSight Myopia Management Program has been explained by the doctor. I have been given the opportunity to ask any questions regarding the therapy and I am satisfied with the answers provided. I agree to enroll in the MiSight Myopia therapy program and agree to all the information indicated in this document.

Patient Signature (parent if under 18)

Date