EYE CARE CLINIC

Clinic Address

Phone / Email

INVOICE

Date
Invoice #

Patient Name
Patient ID / DOB
Optometrist / Provider
Evaluation Type (Spherical, Toric, Multi-focal, Specialty)

Description of Services	Amount
Comprehensive Contact Lens Evaluation & Fitting Fee	$
Follow-up Assessment(s)	$
Specialty Testing / Topography (if applicable)	$
Total Fee Due:	**$**

Notes / Follow-up Schedule

Evaluation fees cover professional services and trial lenses for 90 days. Fees are non-refundable.

Thank you for choosing our practice for your vision needs.