Sound Vision Care, Inc.

Jeffrey Williams Sr., OD | Massala Reffell, OD, MBA, | Jeffrey Williams Jr., OD | Monika Murawska, OD |Cynthia Wiener, OD

Riverhead	Southold	Westhampton Beach	Coram	East Setauket
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(631)727-2858	(631)765-3092	(631)283-0220	(631)732-0822	(631)679-6909
(631)727-2866 (fax)	(631)765-3046 (fax)	(631)286-0299 (fax)	(631) 732-0018 (fax)	(631) 675-6910 (fax)

Gentle Vision Shaping System Agreement

Date: _____ ID: _____

The Gentle Vision Shaping System includes:

- Initial Gentle Vision Shaping System evaluation, fitting and consultation
- ALL lens changes made by the doctor within the first 24 months
- Final pair of lenses, plus spare - Not valid if any lenses are broken or lost.
- ALL topography testing
- 1 Comprehensive eye exam
- 2 year Gentle Vision Shaping System maintenance

The Gentle Vision Shaping System maintenance:
After 24 months into the Gentle Vision Shaping System there is a maintenance fee of $375 each year.

The Gentle Vision Shaping System evaluation:
The initial Gentle Vision Shaping System evaluation is complimentary. The initial evaluations measurements and treatment plans drafted will expire after 3 weeks and you will need a new evaluation at a cost of $350.

Lens Replacement Fees:
Gentle Vision Shaping System lens replacements are $200

Guarantee:
If extenuating circumstances prevent you from continuing treatment within the first 3 months of care, Sound Vision Care, Inc. will refund any fees paid in excess of $750.

Fees:
Each Gentle Vision Shaping System has customized measurements, prescriptions and treatment plans which determine the cost. Based on these factors and our assessment today, the following Level of treatment is marked below:

Level 1 (-3.75 and below): $3000 ____
Level 2: (-4.00 thru -4.75): $3500 ____
Level 3: (-5.00 thru -5.75): $4000 ____
Level 4: (-6.00 thru -6.75): $4500 ____
Level 5: (-7.00 thru -7.75): $5000 ____
Level 6: (-8.00 and above): $5300 ____

I have read, understood and agree to the terms above:

Patient Name: _____

Patient Signature: _____

Parent Name: _____
(patients under 18)

Parent Signature: _____
(patients under 18)