

Tribe _____

Insurance _____

Benefit _____

GLASSES AGREEMENT

Please review the following as an understanding and agreement to the terms outlined below.

- I understand that I have 90 days from when the glasses were ordered, to bring them back to CPNHS Optometry Department if I have trouble with them for a prescription re-check (after 90 days may result in a fee for changes).
- I understand that my frames have a one year warranty against manufacturer defects and that my lenses may be replaced due to scratches one time within one year.
- I understand that if I attempt to repair my own glasses and/or do not have all the pieces/parts to the frame, the warranty will be voided and I will be responsible for all repair costs.
- I understand that if my glasses are lost/stolen I will be responsible for the cost of replacements before they will be ordered.
- I understand that if I bring in my own frame, CPNHS Optometry Department is not responsible if they break.
- I understand that CPNHS is the payer of last resort and will exhaust all resources in order to remain payer of last resort. Third party resources will be applied if accepted to exam and glasses orders. Resources include: Tribal Benefit, Vouchers, Private Insurance, and Health Aids.
- I understand that the Eyewear Program with CPNHS Optometry Department is authorized one time every two years for tribal members, and can be used towards the order of glasses up to \$250.00.
- I understand any overage amount over the allotted \$250.00 is my responsibility.
- I understand any overage payment is required before product can be ordered.
- I understand that any modifications to the glasses after the order is placed may result in a fee.
- I understand that CPNHS accepts cash, money orders, cashier checks, and credit cards as payment. Credit cards accepted are MasterCard, Visa, and Discover (Personal checks are not accepted at this time).
- I understand that if I choose to have my glasses mailed there will be a \$10.00 Shipping fee, and a signature will be required on package.

Printed Name _____

Signature _____ Date _____

(CLINIC USE) CONTACTS DISPENSED TO:

Printed Name _____

Signature _____ Date _____

Optometry Signature _____

Frame _____ Color _____ Size _____

Transitions
 AR

O51 Extra package (Tint, UV, SR) _____	O60 Edge Roll & Polish _____	O40 Trifocal-Plastic _____	V230 _____
O52 Tint Plastic V2741 _____	O62 Transition Tint _____	O41 Trifocal- Glass _____	V230 _____
O53 Tint-Glass V2742 _____	O67 Other _____	O42 Tri-High Index/Polycarp _____	_____
O54 Photochromic-SV V2741 _____	O34 Single Vision-Plastic V210 _____	O43 Progressives-Plastic _____	_____
O55 Photochromic- Multifocal V2741 _____	O35 Single Vision- Glass V210 _____	O44 Progressive-Glasses _____	_____
O56 Scratch Resistant Coating V2760 _____	O36 SV- High Index/Polycarp _____	O45 Progressives-High Index/Polycarp _____	_____
O57 UV Coating V2755 _____	O37 Bifocal-Plastic V220 _____	O63 Frame _____	V2020 _____
O58 Anti Reflective Coating V2750 _____	O38 Bifocal-Glass V220 _____	O66 Misc. Frame Part/Parts _____	V2030 _____
O59 Prism V2715 _____	O39 Bifocal-High Index/Polycarp _____	Total _____	_____