



## Primary Eye Care Center of Ahwatukee

Dr. Michael De Rubeis  
Optometrist  
Treatment of Eye Diseases



16515 S. 40<sup>th</sup> Street, Suite 111 Phoenix, AZ. 85048 (480) 706-2020

---

## CORNEAL REFRACTIVE THERAPY AGREEMENT

We welcome you into our Corneal Refractive Therapy (CRT) treatment program. You are beginning an exciting program designed to reduce and/or eliminate your dependency on eyeglasses or contact lenses during the day by reducing or eliminating your myopia (nearsightedness).

Paragon CRT<sup>®</sup> therapeutic lenses will gently and non-surgically reshape your corneas as you sleep.

### DURATION OF TREATMENT

The length of your treatment will be primarily determined by your prescription, and your compliance with the prescribed CRT wearing schedule. Typically, we expect to see 90% of the vision changes within the first week of treatment and full treatment within two to three weeks. Some eyes will require a longer period of time to complete the process. Thereafter, the lenses will have to be worn routinely to maintain treatment vision.

### PROFESSIONAL FEES

The fee for CRT includes all professional services and all Paragon CRT therapeutic lenses that are required to complete the treatment, for a period not to exceed (3) three months. (Please note—treatment for other conditions, such as an eye infection or a retinal problem, which may arise are not included in the CRT packaged fee.)

Your Corneal Refractive Therapy treatment will begin on \_\_\_\_\_, and will conclude on \_\_\_\_\_.

The following fee is inclusive and includes all the office visits and treatment lenses necessary during the above treatment period.

The total fee for our services related to your Corneal Refractive Therapy treatment, including all treatment lenses prescribed (and a spare pair of CRT lenses) is:

**\$1295.00.**

*This fee must be paid before your Paragon CRT therapeutic lenses are dispensed.*

## **SPARE PAIR**

We recommend that you always have a spare pair of lenses. Treatment may be compromised if disrupted by discontinued wear due to lost or damaged lenses

A spare pair will be ordered within 30 days of successful treatment. This spare pair of Paragon CRT lenses is included at no extra charge.

Subsequent Paragon CRT lenses (if needed) will be replaced at a cost of \$175 each (\$350 per pair).

## **DISCONTINUATION OF CRT**

It is a rare occurrence in health care that any procedure succeeds in every case. There are risks involved in just about anything in life and CRT is no exception. The risks of CRT are similar to the risks involved with wearing an extended wear contact lens in general. Every effort will be made to make your CRT experience a success. However, there are no guarantees that CRT will work on an individual patient. By signing this agreement you acknowledge and accept that the procedure may not work. Failure could be the result of many causes, including (but not limited to): patient non-compliance, corneas which are resistant to change (too firm), incomplete correction, too much astigmatism or myopia, and corneal distortion.

## **PATIENT RESPONSIBILITIES**

1. Follow all verbal and written instructions.
2. Attend all scheduled appointments.
3. Use only the prescribed lens care system.
4. Comply with the prescribed wearing schedule for the lenses.
5. Report all treatment related emergencies immediately by calling the emergency numbers provided.

## **PROVIDER RESPONSIBILITIES:**

1. Provide clear verbal and written instructions.
2. Provide reasonably convenient office hours for all prescribed visits.
3. Assure the quality of the services and materials provided.
4. Respond to all reported treatment related emergencies in a timely manner.

**INFORMED CONSENT**

\_\_\_\_ I understand that this procedure is designed to change my vision through corneal reshaping.

\_\_\_\_ I understand that I will experience altered vision through my current eyeglasses and/or contact lenses due to the change corneal curvature a result of Corneal Refractive Therapy. There is no guarantee that my uncorrected vision will improve following Corneal Refractive Therapy.

\_\_\_\_ I understand and agree to seek immediate care by calling (480) 706-2020 during regular hours or (480) 330-5081 after hours, should I notice excessive pain or excessive redness.

**TREATMENT PLAN ACCEPTANCE**

*I have read and understand the above, and I am in complete agreement with the contents of this agreement.* The undersigned hereby agree to the terms of this agreement and agrees to perform their responsibilities in an effort to achieve optimum success in the Corneal Refractive Therapy treatment.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**WE APPRECIATE THE CONFIDENCE AND TRUST YOU PLACE  
IN US FOR YOUR CONREAL REFRACTIVE THERAPY.**