

**Company**  
Address Line 1  
City, State, Zip Code  
Optician Name  
Optician Title  
Phone Number

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**Date:**

**Patient Receipt of Contact Lens Prescription/Parameters**

My eyecare provider/contact lens fitter has provided me with a copy of my contact lens parameters at the completion of my fitting. I understand that I am free to purchase contact lenses from my provider or from another source of my choice.

I further understand that this prescription/parameters must be filled as written for base curve, power, material and diameter, no substitutions of these values are allowed.

Furthermore, I understand this practice is not responsible for the performance or quality of contact lenses delivered. **Company** can only secure the source of where they purchase their devices in the event of a recall or defect.

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_