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Clinton Family Eyecare
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Clinton, NJ 08809
(908) 735-5712
www.clintonfamilyeyecare.com

Washington Family Eyecare
123 W. Washington Avenue
Washington, NJ 07882
(908) 689-1214
www.wfeyecare.com

Optometry Savings Plan

The Optometry Savings Plan is designed to provide affordability and greater access to quality optometric care.

With the Optometry Savings Plan there are:

- No yearly maximums
- No Deductibles
- No Claim Forms
- No Pre-authorization requirements
- No Pre-existing condition limitations
- Immediate eligibility (no waiting period)

Benefit Premiums:

Single:	$ 205.00	($ 29.00 Savings)
Dual:	$ 369.00	($ 99.00 Savings)
Family (3)	$ 550.00	($152.00 Savings)
Family (4)	$ 700.00	($236.00 Savings)

+$ 130.00 for each additional family member

Dual plan is for Parent/Child or Husband/Wife/Partner
Family Plan includes family members and children who are enrolled full-time in college until the age of 26 or children who are not enrolled in college until the age of 23.

Coverage

	Discount
Comprehensive Eye Exam	100%
Optomap (Retinal Photo)	100%
MPOD (Macular Pigment Optical Density)	100%
Contact lens Services	10%
Frame and Lenses	10%
2nd Pair/ Sunglasses Frame and Lenses	20%
Lost Eyewear	50%
Medical Eye Exam*	40%
Diagnostic Testing*	40%

Program Exclusions and Limitations

This program is a savings plan, NOT a vision insurance plan. It cannot be used:

- In conjunction with another vision plan
- For services for injuries covered under Workman's Compensation
- For referrals to specialists
- For hospitalizations or hospital charges of any kind
- In conjunction with sales or coupons

This plan is only honored at Clinton/ Washington Family Eyecare.
Plan membership is effective 1 year after effective date. No refunds after payment received.

*Medical insurance can be used in lieu of this benefit, provided we are a participating provider.

Guarantees

Temple to Temple Guarantee- You are covered for any mishap, misstep or mistake. $25 copay per incident within 12 months from date of full price purchase of complete pair of eyeglasses (frame and lenses).

Progressive lens Guarantee- If you are not able to adapt to your new lenses within thirty (30) days, we will remake your prescription in another type of lens. This includes single vision (distance, computer and near lenses) or lined bifocals. **There will be no money refunded to you for the difference between the progressive lenses and the other type of lens that you choose to have made.**

Guaranteed Contact Lens Success Program- We strive to fit every patient with comfortable and clear contact lenses. If you are unhappy with your lenses let us know within thirty (30) days and we will refit you with another brand or refund your money for the cost of the contact lenses. Fitting fees are non-refundable.

Our mission is to provide you and your family with personalized, professional eye care in an atmosphere of uncompromising service, value and friendliness.

We are committed to improve your quality of life through thorough eye examinations, patient education and recommendations based on your individual needs.

Application for Optometry Savings Plan

Patient Name:_____ Date of Birth____/____/____

Address:_____
City:_____ State:_____ Zip:_____

Telephone: (_____)_____-_____ home
(_____)_____-_____ mobile

Please check which plan you are applying for:

_____ **Single** **$ 205.00**

_____ **Dual** **$ 369.00**

Name of 2nd Family Member:_____
Date of Birth:____/____/____

_____ **Family (3) $ 550.00**

Name of 2nd Family Member:_____
Date of Birth:____/____/____

Name of 3rd Family Member:_____
Date of Birth:____/____/____

_____ **Family (4) $ 700.00**

Name of 2nd Family Member:_____
Date of Birth:____/____/____

Name of 3rd Family Member:_____
Date of Birth:____/____/____

Name of 4th Family Member:_____
Date of Birth:____/____/____

_____ Additional Family Members

Name: _____
Date of Birth ____/____/____
Name: _____
Date of Birth ____/____/____
Name: _____
Date of Birth:____/____/____

Total # of additional family members ____ X $130.00= _____

Total amount due: $_____

Our office accepts cash, checks or credit cards.
Care Credit can also be used with 6 months 0% financing. Call our office for more details.

Program Guidelines
No credit or refund for any unused Savings Plan benefit.
Plan membership is not for resale.
Plan membership in not transferable.
Plan membership is valid for one year after effective date.
Please schedule routine eye care appointments within one year for all family members.
Patient's portion of their bill for contact lens services, glasses and contact lenses is due at the time of service.

Signature of Primary Family Member

X_____ Date____/____/____

Internal Use Only

Total Family Members covered under plan:_____
Date Application Received ____/____/____

Date Payment Received ____/____/____ Payment Type:_____

Authorized Personnel :_____