

Pacific Cataract and Laser Institute

Optometrist Fees for Post-operative Care

Practice Name: _____

Co-Managing Doctor(s): _____

Primary Address: _____

Phone: _____ Fax: _____

Email: _____

Fees for Post-operative Care Provided by My Practice:

Procedure	PCLI FMV Fee*	Your Fee
LASIK / PRK:	\$ 400.00	\$ _____ per eye
RLE – Single-focus Lens Implant:	\$ 300.00	\$ _____ per eye
RLE – Astigmatism and/or Presbyopia Correction:	\$ 600.00	\$ _____ per eye
Implantable Contact Lens (ICL):	\$ 400.00	\$ _____ per eye
Premium Cataract Surgery: - Astigmatism or Presbyopia Correction	\$ 300.00	\$ _____ per eye

*PCLI's fees are determined by a fair market value (FMV) assessment of services rendered and are applicable only when patients choose to receive post-op care at PCLI. Your services and fees may vary.

I understand that patient payment of the above fees to my practice will be processed through the CoFi application, if enrolled, or must be collected from the patient by my practice. I also agree to notify PCLI of any changes to the above post-operative fees.

Doctor signature: _____

Name: _____

Date: _____

Please email this completed form to lori@cofind.com or fax it to 617-507-8278. Thank you!