BOSTONSIGHT®

Device Service Request Form

Patient Name:_______________________ Date of Birth: ______________

PROSE Doctor:_______________________ Phone Number: ______________

Email: ____

Return Mailing Address Street: ______________________________

City, State, Zip: ___________________________________

I have (must choose one):	☐ Plasma Device	☐ Tangible Hydra-PEG® Device
I am requesting:	☐ Reconditioning [1,2]	☐ Other

[1]Reconditioning includes Inspection, Cleaning, Darkening Dots, Plasma or Hydra-PEG® treatment.
[2]Reconditioning DOES NOT remove scratches and may not remove severe deposits.

Other instructions:

Devices are returned via USPS standard at no charge (delivery dates not guaranteed) OR expedited for additional cost.
**No Saturday deliveries. All overnight deliveries shipped on Friday will be for delivery the following Monday.*

Plasma Devices @ $20.00/device

Qty Right: ______

Qty Left: ______

SUBTOTAL: ______________

Tangible Hydra-PEG® Devices (<1 year old) @ $20.00/device

Qty Right: ______ Qty Left: ______

Tangible Hydra-PEG® Devices (>1 year old) @ $45.00/device

Qty Right: ______ Qty Left: ______

SUBTOTAL: ______________

SUBTOTAL FROM ABOVE: ______________

International Delivery (call office): ______________

Overnight Delivery ($45.00): ______________

2-Day Delivery ($30.00): ______________

TOTAL: ______________ ☐ Check included ☐ Website payment

PAYMENT: Include a check payable to BostonSight or pay online at http://www.bostonsight.org/patient-resources
NOTE: International checks not accepted.

PLEASE CLEAN the Device(s) PRIOR to servicing with your regular daily cleaner, rinse well with preservative-free saline, **wipe dry with a soft cloth**, place in a dry contact lens case, and place into a padded envelope with this completed form.

MAIL TO:
BostonSight
Attention: Device Coordinator
464 Hillside Avenue, Suite 205, Needham, MA. 02494
**Tracking Recommended. BostonSight is not responsible for devices until after they are received.*

Please Note: Submitted devices that are broken, cracked or chipped will not be returned due to risk of patient eye injury if used. BostonSight is not responsible for replacement in such cases. Devices that break during servicing shall not be replaced unless the damage is a result of lab error.

BostonSight®

Device Service Request Form

PLEASE ALLOW 5-7 DAYS FOR RECEIPT, PROCESSING, AND RETURN

BostonSight® PROSE Device Service Request Waiver

Service requests include the following: reconditioning (inspection, cleaning and plasma or Hydra-PEG treatment), and darkening of dots (reapplication of ink for identification purposes).

Indications/Reasons for Service Request

- Device no longer appears clean after nightly cleaning/disinfection
- Increase in discomfort, friction, or stickiness especially upon blinking with prolonged wear or at the end of the day with device wear
- Increased clouding/fogging with device wear
- Increased use of preservative-free artificial tears to improve vision/comfort with device wear
- Increased need to remove, clean, and re-apply devices to improve vision/comfort
- Inability to distinguish number/presence dots for identification on devices
- Inspection of device integrity, scratches, chips, and device warpage

Device Servicing Risks

Risks include, but are not limited to, crazing of device material (becomes opaque and unusable), damage or breakage, no improvement in symptoms and need for repeat servicing. If the device becomes unusable through normal device servicing, the patient is responsible for replacement of the devices and associated charges. If the devices are not reproducible, (typically, but not limited to, designs that are 5 + years old) the patient would be responsible for a retreatment (the comprehensive process of device customization/fitting) and associated charges. If you have any questions, please contact the Device Coordinator at 781-726-7476 prior to sending devices.

Patient Statement

I have read and understood the content of this form and the potential risks and benefits of device servicing. My signature below acknowledges that I voluntarily give my authorization and consent for the Device Service.

Patient Name:____ Date:___________________________

Patient Signature or Authorized Representative: ____