

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® DeviceI am requesting: Reconditioning ^{1,2} Other¹Reconditioning includes Inspection, Cleaning, Darkening Dots, Plasma or Hydra-PEG® treatment.²Reconditioning 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 @ \$25.00/device**

Qty Right: _____

Qty Left: _____

SUBTOTAL: _____**Tangible Hydra-PEG® Devices (<1 year old) @ \$25.00/device**

Qty Right: _____ Qty Left: _____

Tangible Hydra-PEG® Devices (>1 year old) @ \$50.00/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.

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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: _____