



EST. 1961

PEARLE VISION™

SIGHT PASS

Date: _____

Name of Patient: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____

Please indicate below, the **SIGHT PASS** services that your club will provide

SINGLE VISION: Flat-Top 28 in Basic CR-39

_____ Our club will pay **\$100.00**

PROGRESSIVE: Single vision Transition, Thin Lens

_____ Our club will pay **\$125.00**

PROGRESSIVE: Transition, Thin Lens

_____ Our club will pay **\$150.00**

Please include the Payment for the full amount or this request will not be processed.

Amount due for this Referral\$ _____

FRAME ALLOWANCE: There will be a maximum of a \$129.00 Frame allowance.

OTHER OPTIONS: Any other options requested by the client will be the responsibility of the client, unless a prior arrangement for funding has been agreed upon with the Lions Club. *Pearle Vision will offer a 20% discount on other options.*

Please indicate

PEARLE VISION CLINIC LOCATION: _____

Club Name: _____ District _____

Club Representative: _____ E-mail: _____

Address: _____ City: _____ Zip _____

Home #: _____ Cell # _____ Work # _____