EST. 1961

PEARLE VISION™

Date: _____ **SIGHT PASS**

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:

_____Our club will pay **$100.00 - (exam and glasses)**

PROGRESSIVE: Thin Lens

_____Our club will pay **$125.00 - (exam and glasses)**

PROGRESSIVE: Transition, Thin Lens

_____Our club will pay **$150.00- (exam and glasses)**

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

Amount due for this

Referral$_____

FRAME ALLOWANCE: Please note that there is a Maximum frame allowance included in the above pricing,

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 #_____