VIRGINIA FAMILY
EYE CARE

Consent to Treat

I hereby authorize Virginia Family Eye Care and its providers to perform eye examinations, diagnostic testing, and medically necessary treatments. I understand the nature of optometric care and consent to such services. If the patient is a minor, I certify that I am the legal parent or guardian and authorized to consent on their behalf. I acknowledge that I may ask questions about my care at any time.

Patient / Guardian Signature: _____

Printed Name: _____

Date: _____