VIRGINIA FAMILY EYE CARE

9509 Amberdale Dr
N. Chesterfield, VA 23236
P: 804-745-1922
F: 804-249-7347

Welcome to Virginia Family Eye Care! We pride ourselves in providing our patients with the best possible care. As part of this, we offer the state-of-the-art Eidon Retinal Imaging Camera. This non-invasive imaging allows us to see a much broader and more detailed view of your retina than is possible without dilation. These photos are valuable in finding and tracking health conditions including glaucoma, macular degeneration, diabetes, hypertension, floaters, and more. We will review your photos with you today and apply them to your medical file for future comparisons. (**Please circle your choice below**)

Yes – I DO want the retinal photo taken, reviewed and saved for yearly comparisons
(A payment of $39.00 will be collected as insurance does not cover this portion)

No – I DO NOT want the retinal photo at this time

Signature: _____ Date _____
(If under 18, Parent or Guardian's Signature)

Are you interested in a Contact Lens Prescription today? (Circle your choice) **Yes–I DO / No–I DO NOT**
If you are interested in a Contact Lens Prescription, there will be a contact lens evaluation fee charged in addition to the routine eye exam fee. This fee may not be covered by your insurance or vision care plan.

Please note, VSP and EyeMed charge for remakes of glasses or frame changes and do not allow us to cancel after the order is placed. Lenses and prescription checks may occur one time within a 3-month period, then regular charges apply. We are unable to provide a refund for returned lenses or frames however we will place a credit on your account, less a 10% return fee, if the return is made within 60 days.

I agree to bill my medical insurance and not my vision plan when medical problems are diagnosed and understand a medical copay may be due. I understand that Vision Plans are designed to assist with cost of care and may not cover all costs. I am able to contact my Insurance and Vision Plan Providers to better understand what services are covered. I authorize payment directly to Virginia Family Eye Care for services rendered. As the responsible party, I authorize the release of any medical records needed to obtain payment from my insurance company. I will be responsible for all costs including and not limited to service and material costs, collections, attorney, court fees and a 3% surcharge on electronic payments. I acknowledge that a more extensive copy of Virginia Family Eye Care's HIPAA Privacy Notice and Financial Policy is available upon request. Inactive records are professionally destroyed after 10 years. I acknowledge these policies and wish to continue with my evaluation today.

Signature: _____ Date _____
(If under 18, Parent or Guardian's Signature)