



VIRGINIA FAMILY
EYE CARE

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

Office Policy and 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.

Financial Responsibility

I authorize Virginia Family Eye Care to submit insurance claims on my behalf to my insurance carrier (with insurance plans participating with Virginia Family Eye Care). I understand that coverage is determined by my insurance or vision plan, not by Virginia Family Eye Care, and that insurance verification is not a guarantee of payment for services rendered. I agree to bill my medical insurance and not my vision plan when medical problems are diagnosed and understand that a medical copay may be due at time of service. I understand that Medicare does not pay for the refraction portion of an eye exam.

Certain services, products, or materials may not be covered by insurance, including but not limited to Refraction or vision exams, Specialty testing, Contact lens evaluations, Eyewear materials or upgrades. Virginia Family Eye Care will inform me of non-covered services when possible, and payment will be required at the time of service. 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.

Any unpaid balance remaining after insurance or vision plan processing will be my responsibility and must be made before I am seen for another appointment. Payments can be made by cash, debit/credit (Visa, Discover, MasterCard, American Express, Apply Pay, Google Pay) or through HAS/FSA. I am aware that a 3% surcharge will apply when payment is made with a credit card.

I understand that full payment for services is due at the time services are provided and that I am financially responsible for all charges incurred, including but not limited to deductibles, co-payments, co-insurance, non-covered services, any balances not paid by insurance or my vision plan, and any collections, attorney and court fees.

For patients under 18 years of age, the parent or legal guardian accompanying the minor is responsible for payment at the time of service.



VIRGINIA FAMILY
EYE CARE

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

Missed appointments / Late Cancellations

Virginia Family Eye Care requests a minimum of 24-hour notice for any appointment changes or cancellations. Missed appointments or appointments canceled without adequate notice may result in a \$35 missed appointment or late cancellation fee. These fees are the responsibility of the patient and will not be submitted to any insurance carrier. Repeated missed appointments may result in dismissal from the practice.

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