Rock Hill Eye Center

Notice of Privacy Policy Consent Form

HIPAA

Due to the Health Insurance Portability & Accountability Act (HIPAA), Rock Hill Eye Center requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company. By signing this form, you acknowledge the receipt of our Notice of Privacy Practice provided by Rock Hill Eye Center. By signing this form, you also consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

Printed Name of Patient: _____

Signature of Patient/Responsible Party: _____

Date: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request the results of tests and procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your health information released to family members or others, you may do so with your signature on this form.

I authorize Rock Hill Eye Center to leave detailed messages/voicemails with the individuals listed below related to specific appointment information, laboratory/pathology results, patient instructions, follow-up care descriptions, prescription refill status, referral, billing, collections, and insurance information.

I authorize Rock Hill Eye Center to leave a detailed message on my:

Home: Yes No **Cell:** Yes No **Business:** Yes No

**** If permission is not granted, only the date, time and location of your appointment will be left on your answering machine/voicemail.**

I authorize Rock Hill Eye Center to release information regarding my eye health to the following individuals:

1. _____

   Relation to Patient: _____ Phone: _____

2. _____

   Relation to Patient: _____ Phone: _____

Signature of Patient/Responsible Party: _____Date: _____

I **do not** wish to have my health information release any person other than myself.

Signature of Patient: _____Date: _____

You have the right to revoke any of these consents, at any time, in writing, to Rock Hill Eye Center 1773 Ebenezer Rd Rock Hill, SC 29732

Rock Hill Eye Center
Financial/Office Policies
Effective 01.01.2026

Insurance
Please bring your insurance cards to every visit. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to check with your insurance company to be sure we participate with your plan. If we do not participate with your plan, you will be responsible for full payment.

If your specific insurance plan requires a **referral**, **it is your responsibility** to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule or to pay in full for all services rendered.

Self-pay patients are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without any insurance card on file with us. Liability cases will also be considered self-pay accounts. It is always the patient's responsibility to know if our office is participating with their plan. If we do not participate with your insurance company, we assume you have decided to see us as a self-pay patient.
I authorize the release of my medical information necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make any payment to Rock Hill Eye Center for services rendered to me.
All co-payments are due at the time of your visit.

Routine vs. Medical
A routine vision exam is a screening exam that is performed to ensure the health of your eye. It is most frequently requested by patients to determine the need for glasses or contacts. Not all insurances cover screening exams or offers vision benefits. It is your responsibility to know if you have vision benefits and how often it may be available. Vision benefits vary according to your specific plan, you will be responsible for payment if your vision exam is not covered. If during your examination it is discovered that you have a medical issue such as eye allergies, redness, burning, itching, dryness, infection, glaucoma, cataracts, diabetes, headaches, or any other eye related medical issue or complaint we will not be able to treat you under your routine vision policy. We will treat the medical problem and bill the visit under your medical insurance.

Returned Checks
Returned checks will incur a $30.00 service charge, added to your account balance.

Refraction
Refraction is the process of determining the eye's need for glasses or contact lenses. This is often done by checking your ability to see an eye chart using corrective lenses. Refraction also provides us with important information about the function of your eyes and may alert us to any problems that are related to other visual conditions. Our refraction fee is $60.00 and generally not covered by medical insurance, including Medicare. **The Refraction fee is payable at the time of service.**

Glasses Check
If you purchase glasses in our optical shop, you have 90 days to return to the office for a no-charge glasses check if you are having difficulty seeing with your new prescription. After 90 days, you will be charged for an office visit and a refraction fee of $60.00

Surgery
We will provide an estimate of your expected **physician** fees at your request. You may also receive a bill from other providers or other facilities for some services.
Fees for cosmetic or elective services not covered by insurance must be paid before your presurg appointment or surgery may be canceled. An estimate of fees will be provided prior to this date and any final fees more than the estimated fees will be billed to you.

After Hours
After-hours calls are for emergencies only and an afterhours charge may apply for patients seen outside of our operating hours. Our afterhours fee is $60.00 and generally not covered by insurance.

Additional Charges
Patients may be responsible for payment of additional administrative charges including but not limited to; returned checks/ insufficient funds ($30.00), copying and distribution of medical records ($0.65 per page), DMV forms ($20.00) and FMLA paperwork and miscellaneous forms ($25.00). Please allow 7-10 business days for the physicians to complete these requests.

Contact Fitting
This fee covers the contact fitting performed by the doctor. This fee is only charged to patients that wear contacts; it is in addition to the services provided during the routine vision exam. Most insurance companies do not cover the contact lens portion of the exam. There are different levels of charges based on several factors and the contact lens technician will explain the fitting charges as they apply. For any questions about contact fitting fees, please contact Optical.

Cancellation / No Show Policy

I understand that if I do not provide at least a 24-hour cancellation notice or do not show up to my appointment I will be charged a fee of $50.00 regardless of whether I am a new or an established patient. This fee must be paid prior to rescheduling your appointment.

- Effective March 1, 2022, any **established** patient who fails to show for their scheduled appointment will be charged a $50.00 fee.
    - You will be called by our office to reschedule your appointment. This $50.00 fee must be paid by the patient prior to being rescheduled for another appointment, **it will not be charged to insurance**.
    - If you fail to show for the new scheduled time, you will be charged an additional $50.00 fee, **it will not be charged to insurance.**
    - A 3rd no show will result in being dismissed from our office as a patient. We will provide you with options for alternate places for your care.
- Effective March 1, 2022, any **new** patient who fails to show for their scheduled appointment will not be called for rescheduling.
- Please arrive for your appointment **at least 20 minutes** prior to your scheduled time. If you arrive more than 15 minutes after your scheduled time, you will be asked to reschedule your appointment.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office.

Medication Refill Policy

When your doctor requests you return at a set timeframe, this is to ensure that you are receiving adequate screening and monitoring of your eye conditions to prevent permanent vision loss. Your doctor reevaluates your need for eye medications at these set time frames to ensure that you are getting the adequate type and dosage of medications. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible prior to your scheduled appointment. Rescheduling your appointment within the timeframe recommended by your doctor will help you to ensure you are receiving the follow up that is medically necessary for your eye condition(s). Not receiving the directed follow up care as recommended by your physician, can result in permanent loss of vision.

If you need a refill on your medication yet have not followed up based on the recommended and scheduled timeframe set by your doctor, we will prescribe a **onetime refill (enough for one month)** in order to give you enough time to schedule a follow up. If a follow-up is not scheduled, **no further refills** will be given.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office.

My signature signifies I have read, understand, and agree to the financial/office policies of Rock Hill Eye Center.

Patient Signature Date

Patient Name: _____ DOB: _____

Email Address: _____

Briefly explain the reason for your visit today to Rock Hill Eye Center.

_____

_____

What pharmacy would you like your medications sent to should you need a prescription. (Please include the name of the town)

_____

Name of your primary care physician: _____

Name of your Referring Physician: _____

Please list any prescription and over the counter medication you are taking, along with the dosage and usage.

None

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list Medication Allergies and the reaction to the medication.

No Know Drug Allergies

_____

_____

_____

_____

Are you currently a smoker: No Yes How many years have you smoked? _____

Are you a former smoker? No Yes When did you quit? _____

Are you currently pregnant? No Yes

Are you currently nursing? No Yes

For Patients 65 and Older

Have you received your pneumonia vaccine? Yes No

Do you have a power of attorney? Yes No

Do you have a Living Will? Yes No