Rock Hill Eye Center

Patient Information

Patient's last name	First	Middle

Street address	City	State	ZIP Code

Sex	Preferred phone (Please indicate if home or cell)	Email

Marital status	DOB	Social Security number

Employer	How did you hear about us?

Emergency Contact

Last Name	First Name	Phone Number

Responsible Party Information

Responsible Party Name	Address (if different)

Sex	DOB	Social Security Number	Preferred Phone

Employer	Employer Phone Number

Authorization

I hereby consent to the treatment for myself, or patient listed on this form. I hereby certify that I assign all insurance benefits directly to Rock Hill Eye Center and I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. This authorization shall remain valid, until written notice is given by me, revoking said authorization.

Signature of Patient/Guardian	Date

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: _____

Briefly explain the reason for your visit today to the 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: _____

Review of Systems

Please circle any of the following issues you are experiencing:

Poor vision	Allergies	Congestion
Eye pain	Hay Fever	Wheezing
Tearing	Hives	Shortness of Breath
Redness	Bleeding	Upset stomach
Jaw Pain	Anemia	Diarrhea
Scalp tenderness	Diabetes	Constipation
Amaurosis fugax	Thyroid Abnormalities	Burning on Urination
Loss of vision	High Blood Pressure	Urinary Frequency
Fever	Rapid Heartbeat	Incontinence
Chills	Headache	Seizure
Weight loss	Stroke	Paralysis
Dry mouth	Joint Pain	Anxiety
Stuffy nose	Arthritis	Depression
Changing moles	Stiffness	Insomnia
Rash	Cough	

Please circle any of the following medical conditions you currently have or had in the past.

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
COVID 19
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
High Cholesterol
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Other: _____

Please circle any of the surgeries list you had in the past.

Appendix
Bladder (Cystectomy)
Breast: Biopsy Lumpectomy Mastectomy
Colon(Colectomy): Colon Cancer Resection
Colon(Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colectomy
Gallbladder (Cholecystectomy)
Heart: Biological Valve Replacement
Heart: Heart Transplant
Heart: Coronary Artery Bypass Surgery
Heart: Mechanical Valve Replacement
Joint Replacement: Hip Right Left Both
Joint Replacement: Knee Right Left Both
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
None
Kidney: Nephrectomy
Liver: Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Pancreas: Pancreatectomy
Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy): Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids Uterine/Cervical Cancer

Please circle any of the following eye conditions you currently have or had in the past.

Allergic Conjunctivitis

Amblyopia

Blepharitis

Cataract: Right Left

Contact Lenses

Corneal Dystrophy Right Left

Diabetic Retinopathy: Background Right Left

Diabetic Retinopathy: Proliferative Right Left

Double Vision

Dry Eyes

Glasses

Glaucoma

Macular Degeneration Right Left

Macular ERM Right Left

Narrow Angles Right Left

Ocular Hypertension Right Left

Ocular Migraines

Pseudoexfoliation

Retina: Tear Right Left

Retina: Detachment Right Left

Retina: PVD Right Left

Retina: Floaters Right Left

Strabismus: Right left

Trauma: Right Left

Other: _____

None

Please circle any of the following ocular surgeries you have had in the past.

Blepharoplasty (Drooping Eye Lids): Right Left

Cataract: Right Left

Cataract: Secondary Right Left

Cornea: Transplant Right Left

Cornea: LASIK Right Left

Cornea: DSAEK Right Left

Cornea: PRK Right Left

Eye Muscle Surgery: Right Left

Glaucoma: Shunt Right Left

Glaucoma: Trabeculectomy: Right Left

LPI for Narrow Angles: Right Left

Ptosis Repair: Right Left

Punctal Plugs: Right Left

Strabismus Surgery

Retina: Laser Right Left

Retina: Injection: Right Left

Other: _____

None

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 breastfeeding No Yes

For Patients 65 and Older

Have you received your pneumonia vaccine? No Yes

Do you have a power of attorney? No Yes

Do you have a Living Will? No Yes

Credit/Debit Card on File Policy

Thank you for choosing Rock Hill Eye Center for your eye care needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. With the changing environment in healthcare, more responsibility of payment is being placed on the patient in the form of copays and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file in our office.

Effective **January 1, 2025**, Rock Hill Eye Center will require all patients to keep an active credit/debit card on file with our office. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility.

Circumstances when your card would be charged include but are not limited to:

- missed or canceled appointments without 24-hour notice
- missed co-payments, deductible and co-insurance
- any non-covered services and/or denial of services allocated to patient responsibility
- any amount not paid by your insurance 60 days after a corrected claim has been file
-

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please ask to speak with our billing department.

Please read through the following FAQ section for further information.

Why the Change? With the changing environment in healthcare, more responsibility of payment is being placed on the patient in the form of copays and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file in our office.

But I Always Pay My Bills, Why Me? Unfortunately, this is not always the case with many patients that receive our services. Most balances owed are very small and are typically less than $150.00. If your balance due is larger than $250.00, we will provide a courtesy call and/or email to let you know we will be charging your card on file and/or establish a payment plan.

Do I Need to Sign the Secured Credit Card Policy? Yes. Your signature ensures an understanding of our financial policy.

How Will I Know How Much You Are Going to Charge Me? When we receive payment from your insurance company, you should also receive an EOB (Explanation of Benefits). The EOB will have a column named "Owed by Patient." This is the deductible/co-insurance/copay amount that you owe. We will charge the credit card on file on the 22nd business day if payment has not yet been received for the remaining patient responsibility amount, if any, as per the EOB. Once charged, we will email you an itemized receipt of payment.

But Wait, I'm Nervous About Leaving You My Credit/Debit Card. We do not store your sensitive credit/debit card information in our office. Your information is encrypted and stored on Intuit's credit card processing platform, which uses PCI-Validated Point-to-Point Encryption (P2PE)—the most secure

technology available—and includes support for EMV chip-card transactions, reducing credit card processing security risks for our patients.

When Do I Give You My Credit/Debit Card Info? Your credit card information must be given to front office staff before you are seen by a provider.

My Health Plan Has a Health Savings Account (HSA) Card. Can I Keep My HSA Card On-File? Yes, you can keep your HSA card on file, however, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

What If I Need to Dispute My Bill? We will always work with you and your insurance company to ensure accurate billing. If a billing error has occurred with your insurance company, we will refund any money owed to you once dispute/error is settled.

What If I Have More Questions? Our staff is happy to speak with you about your account at any time. Please call our Billing Department at (803) 328-0168 during normal business hours with any questions.

_____ I authorize Rock Hill Eye Center to charge the credit/debit card on file per the terms of this policy. This authorization shall remain in effect until Rock Hill Eye Center has received written notification from in of its termination.

_____ In lieu of a card on file, I elected to place a $200.00 deposit for each visit to the office. I understand, I will receive a refund, less patient responsibility once my insurance has processed the claim.

Patient Name: _____DOB: _____

Patient Signature: _____Date: _____