



Patient Information

Patient's last name	First	Middle
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Street address	City	State	ZIP Code
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Sex	Preferred phone (Please indicate if home or cell)	Email
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Marital status	DOB	Social Security number
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Employer	How did you hear about us?
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Emergency Contact

Last Name	First Name	Phone Number
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Responsible Party Information

Responsible Party Name	Address (if different)
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Sex	DOB	Social Security Number	Preferred Phone
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Employer	Employer Phone Number
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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
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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 you 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 02.08.2023

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.

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 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 offer 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 \$10.00 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 \$55.00 and generally not covered by medical insurance, including Medicare. **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 \$55.00

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, copying and distribution of medical records (\$0.65 per page), DMV forms (\$15.00) and FMLA paperwork (\$25.00), miscellaneous forms (\$15.00). 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 regardless of if 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 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 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 with Rock Hill Eye Center today.

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. _____

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 have or had in the past.

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

Other: _____

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

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

Other: _____

None

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

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

Other: _____

None

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

