

**ROCK HILL EYE CENTER
PATIENT RESPONSIBILITY STATEMENT**

Chart #: _____

NON-COVERED CHARGES

Refraction: \$40.00 (The part of the exam that checks a patient to see if they need a prescription or changes in a current prescription....this is usually optional, unless your doctor feels it needs to be done; if you wish not to have this done, please tell the nurse when you go back for your exam.)

After Hours: \$35.00

Surgical Tray: \$35

Contact Fitting: New Spherical Fits: \$70

Existing Spherical Wearers: \$40

New Toric/Multifocal Fits: \$80

Existing Toric/Multifocal Wearers: \$45

Gas Perm Fits: \$80

Sometimes charges are considered non-covered by your insurance company even though it may be a necessary part of your visit. This is why it is very important for us to know if you have a vision plan; they may cover these charges. If or when these charges are not covered, the patient is then responsible for that amount.

There are other instances that may leave the patient responsible for the balance as well.

- If there is no proof of insurance coverage when the pt is seen and it is not brought in within a reasonable time to be billed, after the pt is seen.
- If the pt's insurance is out-of-network and therefore, not billed by our office.
- If the patient has failed to get any required referrals or authorizations.

If, while reading this, the patient or guardian has any questions regarding non-covered charges, please don't hesitate to ask the front office staff. They will be glad to help.

Signature of Patient/Guardian: _____

Print Patient Name: _____

Date: _____

RHEC Initials: _____