

**ARENA EYE SURGEONS
PATIENT INFORMATION**

OFFICE USE ONLY

Acct. No. _____ Doctor _____ Dx _____ Date of Appt. _____

PATIENT INFORMATION PLEASE PRINT Patient Sex: Male Female **Marital Status:** S M D W

Patient Name: _____

Address: _____ FIRST _____ MI _____ LAST _____
Apt. _____ Home Phone: _____ - _____ - _____

City, State, Zip Code: _____ Work Phone: _____ - _____ - _____

Social Security No.: _____ Date of Birth: _____ Cell Phone: _____ - _____ - _____

E-Mail Address (optional): _____ Occupation: _____ FT / PT

Patient Employer: _____ Employer Address: _____

Family Medical Doctor: _____

Who may we thank for referring you to our office? _____

SPOUSE INFORMATION (OR GUARANTOR IF PATIENT IS MINOR) PLEASE PRINT

Name: _____ Date of Birth: _____ Social Security No.: _____

Employer: _____ Employer Phone: _____ - _____ - _____

Employer Street Address: _____ City, State, Zip: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) PLEASE PRINT

Name: _____ Phone Number: _____ - _____ - _____

Relationship to Patient: _____

INSURANCE INFORMATION: RECEPTIONIST WILL COPY ALL INSURANCE CARDS

PRIMARY

Insurance Co.: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

SECONDARY

Insurance Co.: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Treatment received by the **ARENA EYE SURGEONS** may include, but is not limited to, dilation, laser surgery, and diagnostic procedures. Vision may be temporarily impaired for driving and or operation of mechanical equipment. Should you have any questions concerning this, please feel free to ask the technician.

ARENA EYE SURGEONS REVIEW OF SYSTEMS FORM

Patient Name: _____

DOB: _____

Do you have any of the following problems?

System	Yes/No	Date Diagnosed	Condition/Current Treatment/Surgery
EYE: cataracts, glaucoma, macular degenerations, retina problems, injury or surgery, amblyopia or muscle problems	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CONSTITUTIONAL (general): fever, weight loss	<input type="checkbox"/> YES <input type="checkbox"/> NO		
EARS/NOSE/MOUTH/THROAT: dry mouth, hearing loss	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CARDIOVASCULAR (heart): high blood pressure, high cholesterol, arrhythmia, bypass, congestive failure, heart attack	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Cardiologist _____
>Pacemaker/Defibrillator/Stent	<input type="checkbox"/> YES <input type="checkbox"/> NO		
RESPIRATORY (lungs): bronchitis, asthma, emphysema, MRSA, COPD	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Oxygen How many hours _____ <input type="checkbox"/> Sleep Apnea
GENITOURINARY: bladder, prostate, kidneys, dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO Flomax <input type="checkbox"/> Previously Used D/C
GASTROINTESTINAL (stomach): ulcers, heartburn, reflux	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DERMATOLOGIC (skin): skin disorders, rosacea, MRSA	<input type="checkbox"/> YES <input type="checkbox"/> NO		
MUSCULOSKELETAL (joints): arthritis, bone problems	<input type="checkbox"/> YES <input type="checkbox"/> NO		
NEUROLOGICAL (nerves): stroke, MS, Parkinson's, headaches, weakness	<input type="checkbox"/> YES <input type="checkbox"/> NO		
PSYCHIATRIC: depression, anxiety	<input type="checkbox"/> YES <input type="checkbox"/> NO		
ENDOCRINE (hormones): thyroid, diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO		
>Do you take insulin or oral diabetes meds?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Year of diabetes diagnosis: _____
ALLERGIC/IMMUNOLOGIC (allergies/immunity): sinus, seasonal allergies, lupus	<input type="checkbox"/> YES <input type="checkbox"/> NO		
HEMATOLOGIC/LYMPHATIC (blood/lymph): bleeding tendencies, clots, HIV/AIDS, hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO		Type: Treatment: Physician:
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO		Type:
>Are you allergic to any drugs:	<input type="checkbox"/> YES <input type="checkbox"/> NO		List:
>Are you allergic to latex:	<input type="checkbox"/> YES <input type="checkbox"/> NO		

FAMILY HISTORY:		Family Member
Cataracts	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Macular degeneration	<input type="checkbox"/> YES <input type="checkbox"/> NO	
High blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	

SOCIAL HISTORY:	
Alcohol use	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tobacco use	<input type="checkbox"/> YES <input type="checkbox"/> NO
Drug use (recreational)	<input type="checkbox"/> YES <input type="checkbox"/> NO

Patient's Signature/Date: _____

Tech initials/Date: _____ Doctor initials/Date: _____

Tech initials/Date: _____ Doctor initials/Date: _____

Arena Eye Surgeons
262 Neil Ave, Suite 320
Columbus, OH 43215

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. Our practice is committed to providing the best treatment for our patients.

Please read our financial policy and sign prior to treatment.

It is the patient's responsibility to:

- Complete the patient and insurance information form.
- Provide a current insurance card.
- Provide a government-issued identification card.
- Know his/her current benefits.
- Pay co-pays, deductibles and coinsurance as determined by his/her insurance coverage.
- Pay for refractions.

Treatment of minors:

- Parents or guardians will be responsible for payment of any fees not covered by insurance.
- Insurance cards must list the minor's name.
- Unaccompanied minors will not be treated without proper paperwork.

If the patient is having surgery at The Eye Center, the patient will be responsible for:

- The facility fee (The Eye Center) on the 5th floor.
- The anesthesiologist (The Eye Center) on the 5th floor.
- Pre-admission testing.
- Arena Eye Surgeons will bill for the physician fee only.

For any questions regarding your insurance coverage or benefits, please contact:

- Your human resources manager.
- A representative at your insurance company.
- Use the web address/phone number listed on your insurance card.

If you do not have insurance benefits, we accept cash, check, Visa, MasterCard, Discover and CareCredit.

Please let us know if you have concerns or questions. I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date

ARENA EYE SURGEONS

www.ArenaEyeSurgeons.com

262 Neil Ave.
Suite 320
Columbus, Ohio 43215
614.228.4500
614.221.0138 Fax

Peter J. Utrata, M.D.
Robert P. Bennett, M.D.
Curtin G. Kelley, M.D.

John R. Stechschulte, M.D.
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551 W. Central Ave.
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Delaware, Ohio 43015
740.368.5500
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InFocus@ArenaEyeSurgeons.com

Our practice offers two types of office eye exams, medical and routine. Insurance companies handle medical eye exams and routine eye exams differently. Please read this form; select the type of examination you expect today and sign below.

MEDICAL EYE EXAM

- Care of eye disease such as cataracts, retinal problems or glaucoma.
- Evaluation of eye pain, redness, light sensitivity or marked vision changes.

ROUTINE EYE EXAM

- Patient believes she/he has healthy eyes and wants a full eye examination.
- Patient needs glasses or a change in prescription strength.
- Patient's insurance pays for an annual or every two year healthy eye exam.

IMPORTANT FACTS TO KNOW

- ❖ The measurement for a glasses prescription is called a refraction.
- ❖ Refractions are **not** covered by Medicare and are to be paid for by the patient at the time of service.
- ❖ Our office does **not** submit claims to any vision plans.
- ❖ Our ophthalmologists are **not** providers for any vision insurance plans (i.e.; CVC with United Healthcare, VSP/Vision Service Plan, Cole Vision, Vision One, etc.).
- ❖ Our optometrist is a provider for Eye Med only.
- ❖ Contacts and contact lens fittings are to be paid for by the patient at the time of service.

REFERRALS

- Many insurance companies require the patient to obtain a written referral from his/her primary care physician (PCP). If you have an HMO policy or if a PCP is listed on your insurance card, you need a referral to see our doctors (just as you need for any other specialist you visit). You must have this referral **before** you see the doctor. If you have not obtained your referral, please use our phone and call your PCP to obtain your referral.
- The referral can be faxed to our downtown office 614.221.0138 or our Delaware office 740.368.5599.

PLEASE INDICATE THE TYPE OF EXAM YOU ARE REQUESTING TODAY:

Medical Eye Exam -

Referral required? Yes No

I have my referral. Yes No

Routine Eye Exam

Self pay Submit to Eye Med Insurance only

Contact Lens Exam

Contact Lens Fitting

PATIENT SIGNATURE: _____ DATE: _____

Medical Office Receptionist will make a copy if requested.

VISUAL ASSESSMENT

PATIENT NAME : _____ DOB: _____

VISUAL FUNCTIONING

Do you have difficulty, with your glasses, doing the following activities ?

1. Reading small print, such as newspaper print, medicine bottles or telephone book? YES NO
2. Reading large-print books? YES NO
3. Reading traffic signs or street signs at a distance? YES NO
4. Difficulty driving at night ? YES NO
5. Difficulty driving during the day? YES NO

SYMPTOMS

Have you been bothered by:

1. Rings or halos around lights? YES NO
2. Glare caused by headlights or bright lights? YES NO
3. Decreased color vision? YES NO

Visual Goal

1. Do you dislike wearing glasses? YES NO
2. Do you wish to eliminate the need for glasses? YES NO
3. Do you dislike the idea of wearing reading glasses? YES NO
4. Are you aware that there are implants available to you to help eliminate or decrease the need for glasses after surgery? YES NO

Did you need assistance filling out this form because of your vision? YES NO

SIGNATURE _____ DATE _____

ARENA EYE SURGEONS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 8, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices as long as it complies with applicable law. If we make any material revision to this Notice, we will post a copy of the revised Privacy Notice in each of our offices which will specify the date on which the revised Notice is effective. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe some examples that our practice may use and disclose your medical information. These are some examples and therefore, not every permitted use and disclosure is listed.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information about you in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Appointment Reminders: We may use and disclose your health information to provide you with appointment reminders (such as voicemails or letters).

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically and reasonably do so. You must make a request in writing to obtain access to your health information. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years or such shorter time as you may specify. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions (except to the extent required by the Recovery Act for certain cash transactions); but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mary DeLong Telephone: 614.228.4500 Fax: 614.221.0138
Address: Arena Eye Surgeons, 262 Neil Avenue, Suite 320, Columbus, OH 43215
(Notice amended 6/2/04) (Notice amended 7/10/05) (Notice amended 2/8/2010)

ARENA EYE SURGEONS

I, _____ (Print Name of Patient), acknowledge that I received a copy of ARENA EYE SURGEONS' Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

I, _____ (Print Name of Patient), acknowledge that I declined a copy of ARENA EYE SURGEONS' Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

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551 W. Central Ave.
Suite 101
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740.368.5500
740.368.5599 Fax

Welcome to Arena Eye Surgeons,

We trust your first visit with us will meet or exceed your expectations. If any part of your experience with us is not excellent, please contact me. My phone number is 614.228.4500 and my email address is mdelong@ArenaEyeSurgeons.com.

How did you find out about your physician and Arena Eye Surgeons?

Check the appropriate box below:

- Family Member or Friend _____
(Please provide a name so we may send a "thank you".)
- Eye Doctor _____ MD OD
- Other Type of Physician _____ (name)
- Health Insurance Plan _____ (name)
- Arena Eye Surgeons' Staff _____ (name)
- Website
Arena Eye Surgeons Website
Other Website _____
(Please provide name)
- Yellow Pages / White Pages Book
- YellowPages.com
- Internet Search Engine _____ (name)
- Publication _____ (name)
- Community Event/Health Fair _____
- Other (Please List) _____

Please bring this completed survey to your appointment. Thank you for choosing Arena Eye Surgeons as your eye health care provider.

Mary L. DeLong

Mary L. DeLong, MBA
Administrator

Revised 2/1/2010