Arena Eye Surgeons
Patient Registration

Social Security #: ____________________ Date of Birth: ____________ Age: __________

Patient Name: ____________________ ☐ M ☐ F Phone Number: ____________________

Address: ______________________ City: __________ State: ______ Zip: ________

E-mail Address: ____

- **May we leave a message at the number listed (circle) Y N**
- **Do you have an answering machine? (circle) Y N If so, may we leave a message? Y N**
- **Who may we talk to in an emergency? __________________ Phone: ______________**

Please list their relationship to you: ______________ May we speak to them whenever: Y N

- **Additional emergency contact? ____________________ Phone: ______________**

Please list their relationship to you: ____________________

DO NOT LIST YOUR PERSONAL TELEPHONE NUMBER AS AN EMERGENCY CONTACT NUMBER.

Marital status: (circle one) Single Married Widowed Divorced Student

Employer: ____________________ Work Number: __________________ Retired: Y N

Responsible party for insurance and bills: ☐ Patient ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Guardian

Primary Insurance Company: ______________________ I.D. # ____________________
Name on contract: ______________________
Relationship to cardholder: ☐ Self ☐ Spouse DOB_______ ☐ Dependent

Secondary Insurance Company: ______________________ I.D. # ____________________
Name on contract: ______________________

Primary Care Physician: ______________________ Phone # ____________________

Specialist Referral Physician: ______________________ Phone # ____________________

Pharmacy: ____________ Address: ______________________ Phone # ____________

FOR MINORS ONLY:
Child lives with: ☐ Both parents ☐ Mother ☐ Father

Guardian: ____________________ Address (if different): ____________________

Home phone: ____________ Work phone: ____________ ____________________

ARENA EYE SURGEONS
PATIENT HISTORY/MEDICATION FORM

Patient Name: ______________________________ **DOB:** ______________ **Date:** ________________

MEDICATION (including over the counter and herbal)	STRENGTH	DOSAGE	FREQUENCY (once a day/twice a day, etc.)

Do you have allergies to any medications? (please list below)

Medications: ____

____

____

____

____

____

Patient Signature: ____________________________ **Date:** ________________________

Tech Signature: ____________________________ **Date:** ________________________

Patient Signature: ____________________________ **Date:** ________________________

Tech Signature: ____________________________ **Date:** ________________________

ARENA EYE SURGEONS REVIEW OF SYSTEMS FORM

Patient Name: ____________________ DOB: ______________ Date: ____________________

Please circle any/all that pertain to your medical health

Eyes

Cataract
Glaucoma
Macular Degeneration
Retina problems
Amblyopia
Surgery or any Injury to the eye(s)
Other: ___________________

Cardiovascular

High blood pressure
High cholesterol
Arrhythmia
Bypass Surgery
Congestive Heart Failure
Pacemaker/Defibrillator/Stent
Other: ___________________

Dermatology

Skin disorders
Rosacea
MRSA Other: ____________

Psychiatric

Depression
Anxiety
Other: __________________

Hematologic/Lymphatic

Bleeding tendencies
Clots
HIV/AIDS
Hepatitis – type ___________
MRSA Other: ________________

Constitutional/Symptom

Chills
Fever
Weight loss Other: _________

Cancer

Type -
Date –

Respiratory

Emphysema
Bronchitis
Asthma
COPD
Sleep Apnea C-Pap Bi-Pap

Oxygen use: yes no
How many liters:___________

Musculoskeletal

Arthritis
Bone problems Type: _________

Endocrine

Thyroid
Diabetes – Type I Type II
Type: Diet Insulin Oral

ENT and Mouth

Dry mouth
Hearing loss
Use of hearing aids
Right Left or Both ears
Other: _________________

Genitourinary (G.U.)

Prostate
Kidneys
Dialysis
Use of Flomax/family
Bladder Other: __________

Neurological

MS
Parkinson's
Headaches
Weakness Other: ____________

Allergic/Immunologic

Seasonal allergies
Sinus
Lupus
Adhesive Allergy: Yes No
Latex Allergy: Yes No
Date Tested: ________________

Family History/Member of family

Cataracts
Glaucoma
Macular Degeneration
High Blood Pressure
Diabetes

Social history

Alcohol Yes NO
Tobacco Use Yes No
Drug Use (recreational) Yes NO

Allergies to medications – Please List:

Patient's signature: ________________________________ Date: _________________________
Tech's initials: ______________ Physician: _______________________ 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.
Karl S. Pappa, M.D.
Carrie A. Lembach, D.O.
John R. Stechschulte, M.D.
Curtin G. Kelley, M.D.
Wendy Kirkland, M.D.
Gregory W. DeNaeyer, O.D.

551 W. Central Ave.
Suite 101
Delaware, Ohio 43015
740.368.5500
740.368.5599 Fax

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. Driving at night ? ☐ YES ☐ NO
5. 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

SIGNATURE____ DATE________________

ARENA EYE SURGEONS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), limits the uses and disclosures of Protected Health Information ("PHI"). For these purposes, PHI means any information, including genetic information, (oral or recorded in any form or medium) that is created or received by health care provider (among others), identifies an individual and relates to: the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. PHI excludes information in education and employment records or regarding persons who have been deceased for more than 50 years.

OUR OBLIGATIONS
As a health care provider, **Arena Eye Surgeons** (sometimes referred to as "we") is required by law to maintain the privacy of PHI and, upon request, provide you with notice of our legal duties and privacy practices with respect to PHI and to notify you if a breach of your unsecured PHI occurs.

We are required to abide by the terms of this Notice until it is no longer in effect. We reserve the right to revise the terms of this Notice. If we revise this Notice, the revised Notice may apply to all of the PHI that we have on the effective date of the revision, as well as to PHI created or received after that date. The revised Notice will be available upon request.

USES AND DISCLOSURES
This document will serve as your notice that we may use or disclose your PHI, without your authorization, in any one or more of the following ways:

We are required to disclose your PHI to you upon your request subject to some limitations described later.

We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services in conjunction with that Department's regulatory authority over HIPAA compliance.

We may use and disclose your PHI to carry out treatment, payment or health care operations:

- We may use or disclose your PHI to perform our professional services for you.
- We may use or disclose your PHI to obtain payment for the healthcare services we provided. This may include disclosure to any employee benefit plan that covers our services on your behalf. We may use or disclose your PHI in judicial or administrative proceedings regarding payments for health care services we provided.
- We may use or disclose your PHI in order to support our business activities as a health care provider. These activities may include, but are not limited to, training physicians and employees and quality assessment.

We may access and use your list of medications on the Surescripts website.

We participate in an organized health care arrangement through OhioHealth Group, Ltd. (Health^4). Health^4 consists of an organized system of health care in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized health care arrangement in order to facilitate the healthcare operations activities of Health^4.

We may disclose your PHI:

- To our agents (referred to as "business associates" in HIPAA regulations) in the course of our operations as a health care provider; for example, we may disclose your PHI to a person who transcribes our notes into medical records.
- To an authorized public or private entity to assist in disaster relief efforts and/or to family or other individuals involved in your health care.
- To the extent required by federal or state law. The use or disclosure will be made in compliance with such federal or state law.
- For research purposes, provided an appropriate authority such as the Institutional Review Board has waived requirement for individual authorization for disclosure.
- To health oversight governmental agencies for such agencies authorized activities.
- For law enforcement purposes such as responses to legal processes or requests for information about identification or location, or injuries to victims of crimes.
- If it is necessary for law enforcement authorities to identify or apprehend an individual.
- If we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public.

- For national security purposes.
- For public health activities relating to controlling disease, communicable diseases, injuries, disabilities, or bioterrorism.
- In the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.
- To a coroner or medical examiner for such officials to perform their authorized duties. We may disclose your PHI to a funeral director in order for a funeral director to perform authorized duties.
- To comply with worker's compensation laws and other similar programs.

Disclosures, incidental to the permitted disclosures describes above, may occur.

Other uses and disclosures of your PHI will be made only with your written authorization. Those uses and disclosures are limited to (1) psychotherapy notes, (2) marketing purposes, and (3) the sale of your PHI. You may revoke such an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR INDIVIDUAL RIGHTS
You have the right to inspect the PHI about you or about your minor child that is contained in our designated record set. Our designated record set contains medical, billing and payment records that we generate, have generated, and use to perform health care for you. You have the right to obtain a copy, (in electronic or paper form), for a reasonable fee, of all or part of the designated record set of your PHI, subject to some limitations. For example, you may not inspect or copy psychotherapy notes, or information complies in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding.

You have the right to request a restriction of use or disclosure of your PHI, or your minor child's PHI, for treatment, payment, or health care operations or disclosure to family members or others who may be involved in your care as described above in this Notice of Privacy Practices. You should understand that this restriction may hamper treatment or payment for your health care services. You should make this requests in writing to the Privacy Officer listed below, specifically designating the PHI that you want us to refrain from disclosing. We are not required to agree to the restrictions that you may request, unless your request involves (1) disclosures for the purpose of carrying out payment or health care operations, or (2) services or items for which you have paid us in full.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location if customary disclosure would endanger you. We will accommodate reasonable requests, within our ability to comply, at a reasonable fee.

You have the right to request that we amend your PHI, in a designated record set, for as long as we maintain this information. To do so, your request must be made in writing, to the Privacy Officer listed below. Your request may be denied if the information: was not created by us; is not part of our designated record set; would not be available for inspection; or is accurate and complete.

You have the right to request and receive an accounting of certain disclosures we have made of your PHI. The accounting excludes disclosures made: before September 23, 2013, for treatment, payment or health care operations; as you authorized; to family members or friends involved in your care; for national security purposes; incidental disclosures and to law enforcement officials.

You have the right to request a paper copy of this Notice, even if you agree to receive the Notice electronically

You have the right to complain to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Contact of your complaint. We are not permitted to retaliate against you for filing a complaint.

PRIVACY CONTACT
Mary DeLong, MBA, Privacy Officer
Arena Eye Surgeons
262 Neil Avenue, Suite 320
Columbus, OH 43215
Telephone: 614-228-4500
Fax: 614-221-0138

HIPAA PROCEDURES AND OTHER LIMITATIONS
HIPAA regulations also provide for certain procedures for implementing your rights as summarized above and for reviewing denied requests. This Notice is a summary, not a definitive description of HIPAA rights and requirements, and HIPAA may impose additional limitations on your rights.

EFFECTIVE DATE
This Notice is effective beginning July 14, 2017.

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

Revised 2/1/2010

ARENA EYE SURGEONS
www.**ArenaEyeSurgeons**.com

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

Peter Utrata, MD
Karl Pappa, MD
Carrie Lembach, DO
John Stechschulte, MD
Curtin Kelley, MD
Wendy Kirkland, MD
Gregory DeNaeyer, OD
InFocus@ArenaEyeSurgeons.com

551 W. Central Ave.
Suite 101
Delaware, Ohio 43015
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 ______________________________

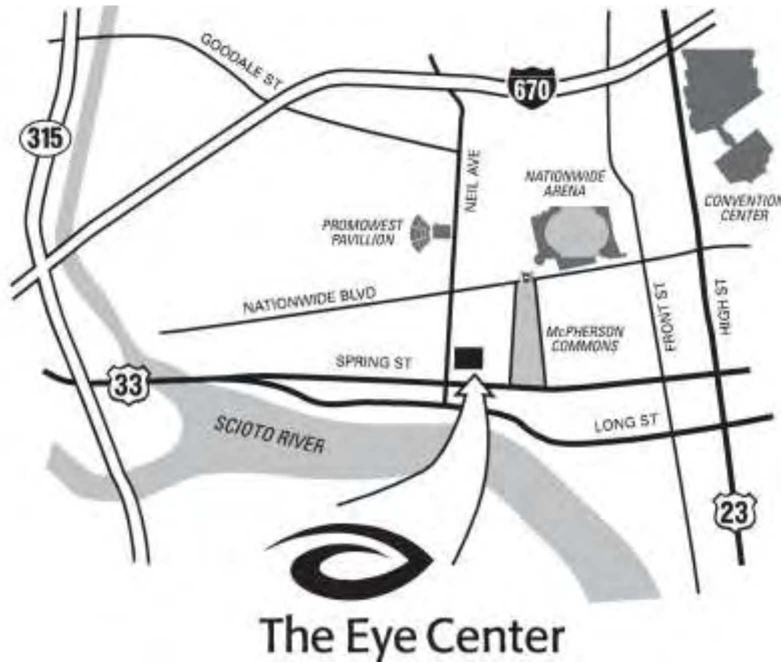
☐ Other (Please List) ______________________________

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 8/27/2015

Directions to Arena Eye Surgeons At The Eye Center



262 Neil Avenue
Suite 320
Columbus, OH 43215
www.arenaeyesurgeons.com

Phone: 614-228-4500 or
888-372-EYES (3937)

Laser Vision Correction
Ph: 614-228-EYES (3937)

Email:
infocus@arenaeyesurgeons.com

FROM THE NORTH

- South on I-71 to I-670 west. Exit at Goodale/Neil Avenue. Turn left at the intersection onto Neil Avenue. Go ½ mile on Neil Avenue. The Eye Center is on the left before Spring Street.
- South on OH-315. Exit at Neil Avenue/Airport. Merge right onto the Neil Avenue exit that turns into the Goodale/Neil Connector. Turn right at the intersection onto Neil Avenue. Go ½ mile on Neil Avenue. The Eye Center is on the left before Spring Street.

FROM THE SOUTH

- North on I-71 to OH-315 to US-33/Long Street exit. Turn right at the intersection onto Long Street. Turn left onto Neil Avenue. The Eye Center will be on your right within 50 yards.

FROM THE EAST

- West on I-70 to I-71 north (exit 101A towards Cleveland). Merge onto I-670 west. Exit at Goodale/Neil Avenue. Turn left onto Neil Avenue. The Eye Center is on the left before Spring Street.

FROM THE WEST

- East on I-70 to OH-315 north. Exit at US-33/Long Street. Turn right at the intersection onto Long Street. Turn left onto Neil Avenue. The Eye Center will be on your right within 50 yards.
- East on I-670. Exit at Neil Avenue. Turn right at the intersection onto Neil Avenue. Go ½ mile on Neil Avenue. The Eye Center is on the left before Spring Street.

PARKING OPTIONS:

- Parking is available in the parking garage adjacent to The Eye Center. **BRING YOUR PARKING TICKET TO OUR OFFICE to receive a reduced rate. Any additional payment of cash must be made at one of the two kiosks located in the parking garage. You may also pay any additional amount by credit/debit card as you exit the garage.**
- There is limited, metered parking available along nearby streets.
- You may also use the valet parking at the entrance of our building **(not eligible for reduced rate).**

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 your current benefits, your referral requirements, and your network 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.

I have read the Financial Policy. I understand and agree to this Financial Policy.

________________________________ ________________________

Signature of Patient or Responsible Party Date

Revised 01/01/2017