

ARENA EYE SURGEONS

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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.