CARL E. FLINN, M.D.

Pediatric Ophthalmology & Adult Strabismus

PATIENT INFORMATION:

NAME (FIRST, MIDDLE, LAST) _____

DOB _____ SEX _____ SSN: _____ RACE: _____ LANGUAGE: _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____ PHONE _____

MARITAL STATUS _____ EMPLOYER _____ OCCUPATION _____

IF PATIENT IS A MINOR WITH WHOM DO THEY LIVE? _____

EMERGENCY INFORMATION:

PATIENT'S PRIMARY DOCTOR _____ PHONE _____

HOW DID YOU HEAR ABOUT US? _____

IN CASE OF EMERGENCY, WHO MAY WE CONTACT **OTHER THAN** PARENTS/GUARDIANS:

NAME _____ RELATIONSHIP _____ PHONE _____

PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

CITY _____ STATE _____ ZIP _____ PHONE _____ SSN _____

EMPLOYER _____ OCCUPATION _____

SECOND PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

PHONE _____ SSN _____ EMPLOYER/OCCUPATION _____

PLEASE PROVIDE A LIST OF ANYONE BESIDES THE PATIENT WHO HAS PERMISSION TO RECEIVE INFORMATION REGARDING ANY OF THE CONTENTS OF THEIR MEDICAL RECORDS?

NAME _____ RELATIONSHIP TO PATIENT _____ PHONE _____

NAME _____ RELATIONSHIP TO PATIENT _____ PHONE _____

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO CONTACT ME VIA TEXT REMINDING ME OF MY UPCOMING APPOINTMENT.
YES CELL # _____ NO

I WANT TO ENROLL IN THE PATIENT PORTAL WITH DR. FLINN'S OFFICE TO RECEIVE MY RECORDS ELECTRONICALLY.
YES EMAIL ADDRESS: _____ NO

SIGNED: _____ DATE: _____

Carl E. Flinn, M.D., Pediatric Ophthalmology & Adult Strabismus

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. FULL PAYMENT IS DUE AT **TIME OF SERVICE** FOR ALL CO-PAYS, CO-INSURANCES, AND/OR DEDUCTIBLES, PLUS ANY PREVIOUSLY OWED BALANCES NOT YET PAID IN FULL. WE ACCEPT CASH, CHECK, or VISA, MASTERCARD, DISCOVER, AMEX.

Insurance

As a *courtesy*, we will file your **medical insurance** *only* if we are a participating provider or on contract with your insurance company. We cannot bill your insurance company unless you give us your insurance information including a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not privy to that contract. **Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under with your medical insurance.** If your insurance company rejects your claim for any reason and/or leaves a balance due, it is your responsibility to pay us in full within **15 days** upon receiving our bill.

Refraction

Refraction is a medically necessary test to determine if you have a need for glasses or contact lenses and to help follow the progress of treatments for diseases of the eye such as cataracts. Dr. Flinn can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). This test helps confirm the extent of vision difficulty and is a necessary component. The information obtained from a refraction test is written as a prescription for eyeglasses or contact lenses. Most insurance plans choose not to cover this essential service. Therefore, you will be responsible for this charge in full ($40).

Referrals

If you subscribe to an insurance company that requires its members to have a referral for each visit, you ***must*** bring your referral to our office at the time of your visit. We regret not being able to see a referral patient because they have failed to bring their referral. Please know that this is not our rule but the rule of the insurance company.

Collection Procedures and Collection Fees

In the event that your account is placed with Universal Collection Systems, a collection fee in the amount of 33 1/3% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all costs of collection including attorney fees and court costs. You agree, that in order for us to service your account or to collect any amounts you may owe, we and Universal may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and Universal may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Returned Checks

There will be a charge in the amount of $20.00 added to your account for each returned check.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge $75.00 for missed appointments. If an appointment is missed twice, there will be a $50 rescheduling fee due before another appointment will be scheduled. Please help us serve you better by keeping scheduled appointments.

Medical Records

There will be a fee per patient for medical records dependent on the amount of records to be copied and disbursed.

Direct Payment

My signature below instructs my insurance company to directly pay: Dr. Carl E. Flinn, 773 Estate Place, Memphis, TN 38120. I also authorize the release of medical information necessary to process my insurance claims.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I hereby acknowledge that I have been made aware of the notice of privacy practices posted by Dr. Carl E Flinn's office. I have been offered a copy of the privacy practices as well. I have read, understand, and agree to the terms of this Financial Policy.

CONSENT FOR TREATMENT OF A MINOR:

I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct Carl E. Flinn, MD and the staff of Carl E. Flinn, MD to provide ongoing routine and emergency health care. This consent shall remain in effect for one year following the date on the consent form or until revoked in writing.

Signed: _____ (Parent or guardian if patient is minor)

Printed: _____

Date: _____