Carl E. Flinn, M.D.
Pediatric Ophthalmology & Adult Strabismus
773 Estate Place
Memphis, TN 38120
(901) 681-4040

Dear Patient,

Dr. Carl Flinn's office wishes to welcome you to our growing number of new patients and to thank you for choosing our office to serve your family's eye needs.

In effort to help make your visit a pleasant experience, we have enclosed our patient information sheets for you to complete and bring on the day of your appointment, and verified your insurance benefits, if available. Please present us your medical insurance card, referral (if needed), and medical specialist co-pay when you sign-in. All visits are filed under medical insurance only. Should you not carry medical insurance or have not met your policy's deductible, payment-in-full will be collected at the end of the exam. For your convenience, we accept cash, checks, Visa, MasterCard, and Discover.

Occasionally, an emergency may occur, and you may need to reschedule your appointment. Please call a day in advance of your scheduled appointment to avoid a fee.

Once again, thank you for allowing us to serve you family's eye needs. Please call our office at (901) 681-4040 if you have any questions.

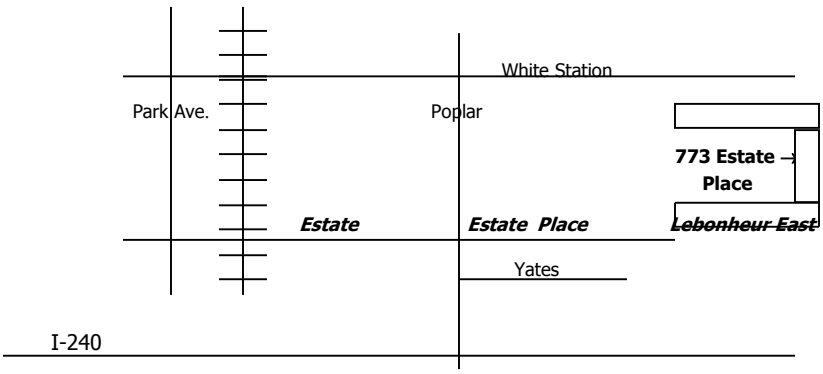
Sincerely,

The Office of Carl Flinn, M.D.

Area Map:

We are located at:

773 Estate Place in the LeBonheur East Complex



PATIENT MEDICAL HISTORY

(Please answer all questions COMPLETELY)

Name: _____ Date: _____
What is the reason for this visit? _____
Who recommended the patient to be seen? _____
Who is the primary care doctor? _____ City/State: _____
Past medical history (list all medical problems, any major illnesses, hospitalizations, or surgeries):

_____

List any previous eye problems: _____
When was the last eye exam? _____ By whom? _____

Is there any family history of:

	YES	NO	Describe
Crossed eyes or offset eyes	____	____	_____
Lazy eye (amblyopia)	____	____	_____
Eye surgery	____	____	_____
Other eye problems	____	____	_____

Current Medications (including eye drops): _____
Adverse or Allergic Reactions to medications: _____
Social history: Does the patient smoke? ____yes ____no Other family members_____
Does the patient consume alcohol? ____yes ____no
Is there a history of blood transfusions and, if so, when was this given? _____
Has the patient been exposed to or contracted the AIDS/HIV virus?_____
Has the patient been treated or recently exposed to Hepatitis? _____
What grade is your child in? _____ School attends: _____
Any problems or difficulties in school? _____
Weight at Birth: _____ On oxygen? _____ Duration: _____

Review of Systems:	YES	NO	Describe
Recent fever	____	____	_____
Weight loss	____	____	_____
Allergies	____	____	_____
Skin rashes	____	____	_____
Ears/Nose/Throat	____	____	_____
Breathing/Asthma	____	____	_____
Heart	____	____	_____
Stomach/Intestines	____	____	_____
Urinary/Bladder	____	____	_____
Joints/Bones/Muscles	____	____	_____
Headaches	____	____	_____

Date: _____ Reviewed by: _____

ACCOUNT #: _____ **PATIENT INFORMATION FORM** TODAY'S DATE: _____

PATIENT INFORMATION:

NAME _____

DATE OF BIRTH _____ AGE _____ SEX _____

ADDRESS _____ CITY_____ STATE_____

TELEPHONE (_____)_____ ZIP_____

IF PATIENT IS A MINOR WITH WHOM DOES HE/SHE LIVE? _____

OTHER FAMILY MEMBERS SEEN HERE? _____

EMERGENCY INFORMATION:

NEAREST RELATIVE ***NOT LIVING WITH YOU***_____ PHONE # (____)_____

NEAREST FRIEND ***NOT LIVING WITH YOU***_____ PHONE # (____)_____

PATIENT'S PHYSICIAN_____ PHONE # (____)_____

REFERRING PHYSICIAN_____ PHONE # (____)_____

IN CASE OF EMERGENCY, CONTACT_____ PHONE # (____)_____

RESPONSIBLE PARTY INFORMATION:

NAME_____

ADDRESS_____

CITY_____ ZIP_____

HOME PHONE # (____)_____

CELL. PHONE # (____)_____

E-MAIL ADDRESS _____

SOCIAL SECURITY #_____

DATE OF BIRTH_____

PLACE OF EMPLOYMENT_____

WORK#_____EXT._____

OTHER PARENT OR SPOUSE'S INFORMATION

NAME_____

ADDRESS_____

CITY_____ ZIP_____

HOME PHONE # (____)_____

CELL. PHONE # (____)_____

E-MAIL ADDRESS _____

SOCIAL SECURITY #_____

DATE OF BIRTH_____

PLACE OF EMPLOYMENT_____

WORK#_____EXT._____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURANCE_____

ID #_____ GROUP#_____

INSURED'S NAME_____

SECONDARY

NAME OF INSURANCE_____

ID #_____ GROUP#_____

INSURED'S NAME_____

FINANCIAL POLICY

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

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 a 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**, unless we are on contract with your insurance company.
WE ACCEPT CASH, CHECK, or VISA, MASTERCARD, DISCOVER.

Regarding 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 do not participate with any vision care policies. The balance is your responsibility whether your insurance company pays or not. 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 a party 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 the Medicare Program and/or other medical insurance.** If your insurance company rejects your claim for any reason, or applies our charges to your annual deductible, it is your responsibility to pay us in full within ***15 days*** upon receiving our bill.

A **refraction** is a necessary part of an eye exam and helps determine any need for corrective lenses. We have found that many insurance companies will not cover the refraction. This expense, if non-covered, would be your responsibility.

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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.

Billing Procedures

We are not a financial institution. We reserve the right to charge a rebilling fee per additional bill. Please help us keep down the cost of billing, which will keep down the cost of doctor's fees.

Collection Procedures

If it is necessary to send your account(s) to collections, you will be responsible for any and all collection costs incurred including reasonable attorney's fees.

Returned Checks

There will be a charge in the amount of $15.00 added to your account for each returned check.

Minor Patients

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard or Discover, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge $75.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Medical Records

There will be a $10.00 fee per patient for medical records.

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.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read, understand, and agree to the terms of this Financial Policy.

X_____ Date_____

Signature of Patient or Responsible Party 2007

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I, _____, hereby acknowledge that I have been made aware of the Notice of Privacy Practices, posted by Dr. Carl Flinn's office.

Signed:_____ Date:_____

(Parent or guardian must sign for patients under 18 years of age.)

I give my permission for Dr. Flinn's office to call or leave a message at the following (circle yes or no):

Home: yes no

Cell: yes no

Work: yes no

Do you have any person(s) with whom we are **not** allowed to speak with on your behalf?

Signed:_____ Date:_____

FOR OFFICE USE ONLY:

If not signed, state reason why acknowledgement was not obtained.

_____