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 & American Express.

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.

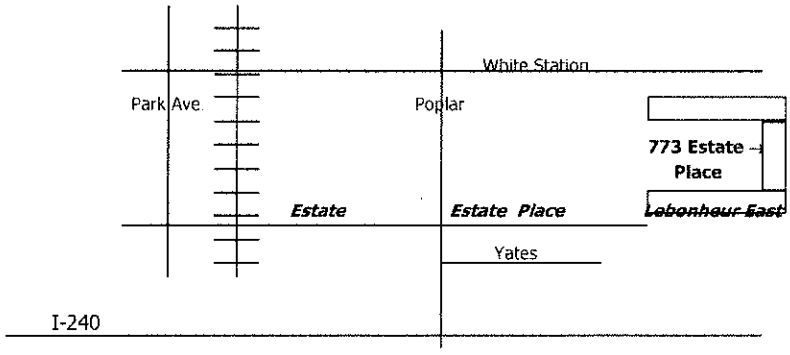
Sincerely,

The Office of Carl Flinn, M.D.

Area Map:

We are located at:

773 Estate Place in the LeBonheur East Complex



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PATIENT INFORMATION FORM

DATE: _____

PATIENT INFORMATION:

NAME: (FIRST, MIDDLE, LAST) _____

DOB: _____ SEX _____ SSN: _____ RACE: _____ ETHNICITY: _____

ADDRESS (STREET, CITY, STATE, ZIP): _____

HOME PHONE: _____ CELL: _____ EMAIL: _____

MARITAL STATUS: _____ PRIMARY LANGUAGE: _____ SPECIAL NEEDS: _____

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

OTHER FAMILY MEMBERS SEEN HERE? (PLEASE NAME) _____

EMERGENCY INFORMATION:

PATIENT'S PRIMARY DOCTOR _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

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

NAME _____ RELATIONSHIP _____ PHONE _____

PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS _____

EMAIL _____ PHONE _____ SSN _____

INSURANCE INFORMATION:

INSURANCE NAME: _____ ID # _____ GROUP #: _____

INSURANCE NAME: _____ ID #: _____ GROUP #: _____

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PATIENT HISTORY FORM

Patient: _____ **DOB:** _____ Date: _____

What is the reason for today's visit? _____

Who recommended the patient to be seen? _____

Who is the primary care doctor? _____ **Phone Number:** _____

Past Medical History:

Infections _____

Behavior Problems _____

Surgeries _____

Hospitalizations _____

Other _____

Social History

Smoking Exposure at Home _ Yes _ No

Does the patient smoke? _ Yes _ No

Does the patient consume alcohol? _ Yes _ No

Does the patient do drugs? _ Yes _ No

Patient's Grade _____ School _____

Does the patient have problems at school?

_____

Birth & Development

Full Term? _ Yes _ No

Birth Weight _____

Birth Complications _____

Pregnancy Issues (meds, alcohol, smoking)

Oxygen used at birth _ Yes _ No

History of Blood Transfusion? When? _____

Medications (including eye drops)? _ Yes _ No

If yes – What? _____

Allergies:

_ None _ Latex

_ Medications _____

_ Environmental _____

What type of reaction? _____

Family History _ Natural _ Adopted

Please circle any that apply to patient's family history:

Bleeding Problems –	Glaucoma –	Hepatitis –	Lazy Eye (Amblyopia) –
Diabetes –	Glasses –	HIV/AIDS –	Strabismus –
Eye Surgery –	Heart Disease –	Hypoglycemia –	Thyroid Disease –

If any of the above are marked, please give a brief description and approximate date:

_____

_____

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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)

CONTACT PERMISSIONS:

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

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

I GIVE PERMISSION FOR DR. FLINN'S OFFICE TO TAKE MY PICTURE FOR:
□ ELECTRONIC MEDICAL RECORDS □ SOCIAL MEDIA

SIGNED: _____ DATE: _____

MEDICAL RECORDS RELEASE:

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 _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

SIGNED: _____ DATE: _____

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.

Parent/Guardian: _____ Date: _____

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Pediatric Ophthalmology & Adult Strabismus

Checklist: Review of Systems

Patient: _____ Date: _____

THIS CHECKLIST IS VERY IMPORTANT. PLEASE CHECK ANY SYMPTOMS THAT YOU MAY HAVE AT THIS TIME.

Eyes-
- ☐ Vision Loss/Change
- ☐ Pain
- ☐ Glasses or Contacts
- ☐ Redness
- ☐ Blurry or Double Vision
- ☐ Flashing Lights
- ☐ Floaters
- ☐ Cataracts
- ☐ Amblyopia
- ☐ Crossed Eyes or Offset Eyes (strabismus)
- ☐ Color Blind
- ☐ Yellow eyes

Last Eye Exam _____

General-
- ☐ Weight Loss or gain
- ☐ Fever or Chills
- ☐ Weakness
- ☐ Trouble Sleeping
- ☐ Cancer
- ☐ Down's Syndrome
- ☐ Diabetes

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair & Nail Changes
- ☐ Non Healing Sores

Head-
- ☐ Head Injury
- ☐ Neck Pain
- ☐ Headache

Ears-
- ☐ Ringing in Ears
- ☐ Decreased Hearing

Nose-
- ☐ Nosebleeds
- ☐ Sinus Pain
- ☐ Discharge

Neck-
- ☐ Swollen Glands
- ☐ Pain

Breasts-
- ☐ Lumps
- ☐ Pain

Respiratory-
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Pneumonia
- ☐ Cough
- ☐ Excess Mucus
- ☐ Coughing up blood
- ☐ Tuberculosis
- ☐ Wheezing

Cardiovascular-
- ☐ Chest Pain or discomfort
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Swelling of extremities
- ☐ Heart Palpitations
- ☐ Congestive Heart Failure
- ☐ Shortness of breath w/activity
- ☐ Difficulty breathing while lying down

Throat/Oral-
- ☐ Bleeding of Gums
- ☐ Dentures
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-Healing Sores

Vascular-
- ☐ Calf pain with walking
- ☐ Leg Cramping

Hematologic-
- ☐ Ease of bruising
- ☐ Ease of bleeding
- ☐ HIV/AIDS
- ☐ Anemia

Psychiatric-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory Loss

Gastrointestinal-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Liver Disease

Urinary-
- ☐ Frequency Issue
- ☐ Kidney Disease
- ☐ Urgency Issue
- ☐ Burning or pain
- ☐ Blood in urine

Musculoskeletal-
- ☐ Muscle or Joint Pain
- ☐ Rheumatoid Arthritis
- ☐ Stiffness
- ☐ Back Pain
- ☐ Redness of Joints
- ☐ Swelling of Joints
- ☐ Trauma – Broken Bones

Neurologic-
- ☐ ADHD
- ☐ Tremors
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Autism
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling

Endocrine-
- ☐ Thyroid Disease
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Hypoglycemia

Reviewed BY: _____ Date: _____

FINANCIAL POLICY
Carl E. 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** 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 do not participate with any vision care policies, except VSP. 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.

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, AMEX, 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.

Rescheduling Fee

If an appointment is missed more than 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 $20.00 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