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

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 (IF DIFFERENT FROM PATIENT) _____

CITY _____ STATE _____ ZIP _____ PHONE _____ SSN _____

SECOND PARENT OR GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____ DOB _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

CITY _____ STATE _____ ZIP _____ PHONE _____ SSN _____

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: _____

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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: _____

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:** _____

REQUIRED INFORMATION:
What pharmacy do you use? Name: _____ **Phone Number:** _____
Cross Streets/Intersection of Pharmacy: _____

Past Medical History:

Infections _____

Behavior Problems _____

Surgeries _____

Other _____

Social History

Smoking Exposure at Home □ Yes □ No

If yes, who smokes in home: _____

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 How many weeks? _____

Birth Weight _____

Birth Complications _____

Pregnancy Issues (meds, alcohol, smoking)

Oxygen used at birth: □ Yes How long? _____ □ No

History of Blood Transfusion? □ Yes, Year ____ □ No

List All Current Medications (including eye drops)

_____

_____

Allergies: □ None □ Latex □ Seasonal

□ Other _____

What type of reaction? _____

Family History □ Natural □ Adopted □ Foster □ Custody

The following information is for the patient's FAMILY history (not the patient's history). Please mark all that apply and specify which relative it applies to and give details such as date diagnosed for each condition:

□ Hypertension □ Glaucoma □ Hepatitis □ Lazy Eye (Amblyopia) □ Diabetes □ Glasses
□ HIV/AIDS □ Strabismus □ Eye Surgery – What kind _____

_____
_____

Any other family health conditions the doctor will need to know about: _____

OFFICE USE ONLY: Reviewed BY: _____ Date: _____

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Checklist: Review of Systems

Patient: _____ Date: _____

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

Eyes-
□ Vision Changes
□ Eye Pain
□ Glasses or Contacts
□ Redness
□ Blurry Vision
□ Flashing Lights
□ Floaters
□ Cataracts
□ Amblyopia
□ Crossed Eyes or Offset Eyes (strabismus)
□ Color Blind
□ Yellow eyes
□ Sudden Vision Loss
□ Double Vision
Last Eye Exam _____

General-
□ Weight Gain
□ Fever or Chills
□ Weakness
□ Weight Loss
□ Cancer - What kind _____
Date of Diagnosis: _____
□ Diabetes- What Type _____

Skin-
□ Eczema
□ Pigmentation
□ Molloscums
□ Non-Healing Sores

Head-
□ Head Injury
□ Headache

Ears-
□ Ear Infection
□ Ringing in Ears
□ Decreased Hearing

Nose-
□ Nosebleeds
□ Sinus Drainage

Breasts-
□ Lumps
□ Pain

Respiratory-
□ Shortness of breath
□ Asthma
□ Pneumonia
□ Cough/Congestion
□ Wheezing
□ Coughing up blood
□ Tuberculosis

Cardiovascular-
□ Congestive Heart Failure
□ Heart Murmur
□ Heart Palpitations
□ Chest Pain or discomfort
□ Heart Attack
□ Heart Disease
□ High Blood Pressure

Throat/Oral-
□ Dry Mouth
□ Sore Throat
□ Hoarseness
□ Strep

Vascular-
□ Calf pain with walking
□ Leg Cramping

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

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory Loss

Last Menstrual Period: _____

Gastrointestinal-
□ Heartburn
□ Nausea
□ Vomiting
□ Constipation
□ Diarrhea
□ Hepatitis A B OR C
□ Liver Disease

Urinary-
□ Kidney Disease
□ Incontinence
□ Blood in urine

Musculoskeletal-
□ Trauma – Broken Bones
□ Swelling of Joints
□ Rheumatoid Arthritis
□ Stiffness
□ Back Pain

Neurologic-
□ ADHD
□ Tremors
□ Down's Syndrome
□ Cerebral Palsy
□ Stroke
□ Autism
□ Dizziness
□ Fainting
□ Asperger's Syndrome
□ Seizures
□ Weakness

Endocrine-
□ Hyper Thyroid
□ Hypo Thyroid
□ Hypoglycemia

Neck-
□ Swollen Glands
□ Neck Pain

A**NY OTHER SYMPTOMS OR DIAGNOSIS' NOT LISTED ABOVE: _____**

OFFICE USE ONLY: Reviewed BY: _____ Date: _____