Flynn Family Medicine offers medical billing and claims services specializing in American insurance companies complying with General Data Protection Regulation (GDPR) – European data protection and privacy law.

1. **RELEASE OF INFORMATION:** I hereby authorize Flynn Family Medicine to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

2. **BILLING OFFICE:** For questions regarding billing statements, payments and other inquiries, please contact our billing office under the number 06371-4078717.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign, transfer and set over directly to this clinic sufficient payment and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic.

I authorize Flynn Family Medicine to contact my insurance company or health plan administrator and contain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information. I authorize Flynn Family Medicine to release all medical information requested by my health insurance carrier, other physicians or providers, and any other third-party payers.

4. **SELF PAY PATIENTS:** I understand that full payment is due upon receipt of invoice.

5. **RESPONSIBILITY FOR PAYMENT:** I understand that Flynn Family Medicine is billing accordingly to the agreement of the insurance companies and that I am financially responsible for charges not covered by the assignment of insurance benefits (e.g. deductibles or copays). I also understand and agree to the fact that services provided will be billed using the customary American CPT standards and not in the German GOÄ system in accordance with contractual arrangements with the American insurance providers.

6. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, accrued interest and fines. These additional fees will be my personal responsibility to pay in full.

7. **PERSONAL CONTACT INFORMATION:** I understand that it is my obligation to update my contact information and to inform Flynn Family Medicine about any changes that may occur. I consent to reminders of my open statements to be sent to me via E-mail and/or address.

PHONE NUMBER:____

EMAIL ADDRESS:____

Please check only one address for correspondence:

PHYSICAL ADDRESS:____

APO ADDRESS:____

I have read, understood and accept the terms and conditions.

____
Patient name (Print)

________________________________ ________________________
Patient Signature Date

New Patient Registration Form

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)		City	Zip
Cell Phone #	Other Phone #	Email:	
Sex (check one) Male ☐ Female	Date of Birth	Age	Social Security #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Spouse's Name (If Applicable)	
Employer Name		Employer Address	

How did you hear about the practice and/or the provider you are seeing today? **Optional

☐ Family Member ☐ Established Patient ☐ Insurance Listing ☐ ER
☐ Hospital ☐ Web Search ☐ Location/Drive By ☐ Other ____________________
☐ Physician Referral

Responsible Party

Complete this section only if the patient is a minor

Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City		Zip Code
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #

Insurance and Subscriber Information

Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City	State Zip	City	State Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City	State Zip	City	State Zip

______________________________________ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**

Version: *24.09.2023*

Health Information Sharing & Emergency Contact(s)

I authorize Flynn Family Medicine to share my medical information with the following individual(s)

Name (please print) | Phone

Name (please print) | Phone

In an emergency I authorize Flynn Family Medicine to contact

Name (please print) | Phone

Name (please print) | Phone

Signature of Patient, Parent, or Legal Guardian | **Date**

Version: 24.09.2023

Consent to Treat & Financial Responsibility

Consent to Treat

I hereby authorize employees and agents of Flynn Family Medicine (including physicians, nurses, and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____

Patient Name (please print)

______________________________________ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for ______________________________ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

______________________________________ ____________________

Signature of Parent or Legal Guardian **Date**

Financial Responsibiltiy

I hereby authorize payment of medical benefits directly to Flynn Family Medicine (hereinafter "FFM") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. understand that this authorization may include release of information regarding communicable diseases, such as Acquired immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to FFM. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of FFM, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

____

Patient Name (please print)

______________________________________ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**