



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: _____

Both addresses are needed-

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		Social Security # (required)	
Address (Street or Box)				City		Zip	
Cell Phone #		Other Phone #		Email:			
Sex (check one) Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth (DD/MM/YYYY)		Age		Estimated PCS Date	
Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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							
<input type="checkbox"/> Family Member		<input type="checkbox"/> Established Patient		<input type="checkbox"/> Insurance Listing		<input type="checkbox"/> ER	
<input type="checkbox"/> Hospital		<input type="checkbox"/> Web Search		<input type="checkbox"/> Location/Drive By		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Physician Referral							

Complete this section only if the patient is a minor

Responsible Party

Last Name		First Name		Middle Name		Maiden Name	
Address (Street or Box)				City		Zip Code	
Home Phone #		Work Phone #		Cell Phone #			
Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		Age		Social Security #	

Insurance and Subscriber Information

Primary Insurance Company			Effective Date			Secondary Insurance Company (VA ONLY)			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 # (required)			Relationship to Patient			Subscriber Social Security #			Relationship to Patient		
<u>If you have another primary insurance, please specify below:</u>											

Signature of Patient, Parent, or Legal Guardian

Date



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



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 Responsibility

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. I 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



Dear Flynn Family Medicine Patient,

At Flynn Family Medicine, we understand circumstances can change. When this happens, we request patients notify us at least 24 hours in advance if they need to cancel or reschedule an appointment. This allows us to manage our schedule effectively and offer the time slot to another patient in need.

Cancellations or rescheduling requests with less than 24 hours' notice will result in a cancellation fee as detailed below. We appreciate your understanding and cooperation in ensuring we can provide timely and efficient care to all our patients. Please note we will consider exceptions for unavoidable emergencies on a case-by-case basis.

The following fees will be effective starting June 1, 2024:

- 15 minute appointment 10 Euros
- 30 minute appointment 20 Euros
- 60 minute appointment 40 Euros
- BH appointment 75 Euros
- Nutritionist 50 Euros

Thank you for your understanding and cooperation,

Your Flynn Family Medicine Team

Printed Name

Signature, Date

Patient IBAN Bank Details Request Form

Flynn Family Members

Schulestraße 2 Ramstein-Miesenbach 66877

Phone:06371 9527070

Email:registration@flynnsmedical.com

Patient Information

Full Name:	
Date of Birth:	

Bank Account Information (for refund purposes only)

Account Holder Name:	
IBAN:	
BIC / SWIFT Code:	

Important Notice

The information provided above will be kept strictly confidential and will only be used by **Flynn Family Medicine** for the purpose of issuing a refund over payment purpose, if necessary. It will not be shared with third parties except as required by law.

Patient Declaration

I, the undersigned, confirm that the above banking details are correct and authorize **[Clinic / Hospital Name]** to use this information exclusively for processing refunds, should they become applicable in the future.

Signature: _____

Date: _____