Dr. Vincent Ho
3225 Shallowford Rd Bldg 1300
Marietta, GA 30062
678-560-7160
Fax: 678-560-7185

Welcome to our Practice!

Please take a few minutes and complete the following paperwork so we can better assist you with your health care needs.

PATIENT & FAMILY INFORMATION:

Name: _____ Birthdate: _____ M____ F____

Home # _____ Cell# _____ Work #_____

Address: _____

City: _____ State: _____ Zip: _____

School or Employer: _____

INSURANCE INFORMATION:

Insurance Company: _____

Mental Health Coverage:

Did you confirm your MH coverage with your insurance? ____Y____N
Do you need Prior Authorization for visits? ____Y____N
Is Your MH covered under same Company? ____Y____N
If No, Please provide Insurance Name _____

Primary Card Holder: _____ Birth Date: _____

Social Security #: _____

Home #: _____ Cell# _____ Work# _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Please Sign BOTH Disclosures

Authorization for Disclosure of Information

By signing below I hereby consent for the Practice to use or disclose information about myself (or for the person whom I have the authority to sign for) that is protected under federal law, for the sole purposes of treatment, payment, and health care operation.

Parent/Guardian Signature X _____ Date: _____

Authorization for Guarantee of Payment

I authorize payment of medical benefits to Sandy Plains Pediatrics. I will be responsible for the FULL amount of the charges except those under Sandy Plains Pediatrics contractual arrangements with certain insurers.

Parent/Guardian Signature X_____ Date: _____

Dr. Vincent Ho, Psychiatrist
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We are glad that you have chosen our practice for your Mental/Behavioral Health needs. PLEASE complete the attached paperwork and obtain the proper authorization prior to your first appointment. We will not be able to see you without this information.

Mental/Behavioral Health insurance usually does not fall under your regular medical insurance. Your employer determines who the MH company is (for example -the medical insurance may be Blue Cross Blue Shield however the MH company may be Magellan or Value Options). Please complete the following steps in order for us to properly file your insurance claims for the initial appointment & follow up visits.

1. Call the mental/behavioral health number listed on the back of your insurance card. If there is not a number listed, please call the customer service number to verify your coverage.
2. Advise the insurance representative that you will be seeing Dr. Vincent Ho, Psychiatrist (Tax ID # 582523113) for an initial Outpatient Evaluation visit. The Procedure code is 90801. Then follow up visits will be procedure code 90805.
3. Please obtain the following information:

   Mental Health Insurance Company Name _____
   Billing Address _____
   Phone # _____

   Deductible Individual _____ Family _____
   Copay $ _____
   Co-insurance _____
   Authorization # _____
   # of Visits allowed _____
   Dates of Auth Begins _____ Expires _____

3. We realize that a patient's insurance plan may change over the course of the year. **It is your responsibility to update us with these changes & to obtain authorization any time a change occurs.** Many insurance companies have a 60 or 90 day filing limits. Failure to provide us with the updated information & new authorizations may result in your responsibility for the billed amount for that date of service.

4. If your insurance company requests information from you in order to process our claims, please provide the information as soon as possible. If the information is not provided within 30 days of the request, the balance will become your responsibility.

5. Co-pays and outstanding balances from deductibles, coinsurance or missed appointments are due at the time of service, regardless of who brings the child in for the appointment. Please do not place our practice in the middle of divorce or marital disputes. It is your responsibility to work out payment arrangements for your child's medical care. We will be happy to provide you with a receipt for your payment so that any money due to you can be recouped. A $15.00 billing fee will be charged for failure to pay at time of service and future appointments will not be scheduled until balances are paid.

6. If you do not have insurance that covers mental health, you will receive a discount on your visit however payment in full will be expected at the time of service.

7. The following charges are your responsibility and will be paid at the time of the request or occurrence and will not be billed to your insurance company:
   - $20 for requested letter to be written on a patient's behalf
   - $20 for request of Medical Records per chart
   - $25 for missed appointments or those cancelled less than 24 hours
   - $15 billing fee as stated above for failure to pay co-pay or balance

I acknowledge that I have received and read the above Financial Policy and accept all financial responsibility as stated above.

Patient Name _____ Parent/Guardian _____
Please Print Please Print

Patient/Guardian Signature _____ Date _____

Past Medical History

Please complete the following information

Patient's Name: _____ **Birth date:** _____

Previous Medical History:

Allergies: _____

Primary Care Physician: _____

PCP Office # _____ **Fax #** _____

Date of Last Well Checkup: _____

Medical Conditions: (Diabetes, Hypertension, Head Trauma, Heart/Cardiac Problems, Asthma, Cancer, or any other medical problems you have had): _____

_____

_____

Current Medications: _____

_____

_____

Past Psychiatric History (Mental Health & Chemical Dependency):

Previous Outpatient Therapy

Previous Practitioners & Dates of Treatment: _____

_____

_____

Previous Treatment or Medications: _____

_____

_____

Past Hospitalizations (Include dates & location): _____

_____

_____

Current Psychologist/Counselor: _____

Phone # _____ **Fax #** _____

Length of time w/ current therapist: _____

Please complete the following for all patients 12 & over:

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Nicotine/Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Dr. Vincent Ho
Waiver For Mental Health Visits

I _____, agree and consent to participate in the behavioral care services offered & provided by, Dr. Vincent Ho, Psychiatrist. I agree to accept full responsibility & payment for any visits with Vincent Ho, MD, in the event that my insurance company does not cover the date of service, or the services rendered are not covered. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of the stated named patient below and authorize to consent for treatment and services.

Patient's Name:

_____

Responsible Party's Name:

_____

Relationship to Patient:

_____

Responsible Party's Signature:

_____

Today's Date: _____

Verification of eligibility and benefits does not guarantee that the visit will be covered. *

Thank you,
Sandy Plains Pediatrics & Dr. Vincent Ho

Sandy Plains Pediatrics & Dr. Vincent Ho, Psychiatrist
The Practice
Health Insurance Portability and Accountability Act (HIPAA)
Policy 2

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS.

By signing below, you hereby consent for this Practice to use or disclose information that is protected under federal law, for the sole purposes of treatment, payment and healthcare operations for you or persons for whom you have the authority to sign for.

YOU MAY REFUSE TO SIGN THIS CONSENT FORM.

You should read the Notice of Privacy Practices for PHI. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Front Office.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however, if the Practice agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on you authorization (as determined by our Privacy Offer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject re-disclosure by the receipt and may no longer be protected under federal law.

The individuals that you list below will have access to information regarding you condition and /or treatment:
(This should include anyone who plays a part in you/your child's care including but not limited to both parents, Primary Care Physician, Psychologist/Counselor, School, grandparents, care giver, etc...)

_____ _____

_____ _____

You may communicate information, including invoices for services to the following address and or phone numbers:

Address _____

Phone Number _____

Individual Signature _____ **Date** _____

As a Personal Representative, I have the authority to act for the individual because I am the individual's:

_____

Name of Patient _____ **Date of Birth** _____

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We are pleased that you have chosen us to be your provider for your Mental Health needs. In order to provide you with the best & most efficient care we are asking you to review the following information and follow these few guidelines.

- Insurance Coverage – **Please call the Mental Health # listed on the back of your card to verify your insurance coverage prior to the first visit, at the beginning of a new year or any time your insurance coverage changes.** You need to make sure that Dr. Vincent Ho is in network, what your copay will be, if you have a deductible & if you need to have preauthorization prior to the first visit. Each person's Mental Health coverage is different. Just because we may be contracted with a company does not guarantee that you are covered. You also may have a totally different provider for Mental Health – for example some of the Blue Cross Blue Shield plans are covered by a company called Magellan Behavioral Health. **You will be responsible for the visit if your plan does not cover Mental/Behavioral Health, if we do not have the correct insurance information at the time of your visit or authorization needed has not been obtained prior to your visit.**

- Seeing another Provider – If you are seeing a counselor/Psychologist along with Dr. Ho, please let us know & do not schedule appointments on the same day. Insurance usually only allows you so many visits per year & this will include both providers. Please know how many visits your plan will cover & keep track of those visits. We have also found that many insurance companies will only pay for 1 provider on a given day.

- Missed or No Show Appointments – Due to our growing patient census, we have a waiting list for people to get in to see by Dr. Ho. Please be considerate and call to cancel your appointment if you can not make it. We would like to have **24 hours advance notice.** If you do not call & do not show up for your visit, you will be charged a **$25 No-Show fee.** This will include calling within a few hours of the appointment or any time after the appointment. **After 3 No-Show appointments we will no longer be able to see you as a patient.**

- Office Hours – Dr. Ho & Julie are in the office **Monday – Thursday from 8:30 – 4:30 only.** Please call for any concerns or medication refills during this time. Any calls on Friday will be returned the following Monday including refills. Please call the main **# 678-560-7160** and press # **6** to leave a voice mail. Julie will return your call as soon as possible.

- Prescription Refills – Please call **Monday – Thursday** for any prescription refills and **allow 24 hours** for us to refill. We will notify you when your script is ready. Any ADHD/ADD medication refills have to be **picked up** at the front desk & signed for per State Laws during business hours. ***We can not mail, call in to a pharmacy or leave these scripts outside after hours.

- Letters from Dr. Ho – Due to the increase in requests for letters from Dr. Ho regarding your care, we are now charging **$20 per request.** We also ask that you allow 1 week for the letter to be prepared.

Signature _____ Date _____