

Dr. Vincent Ho, Psychiatrist
3225 Shallowford Road, Bldg 1300
Marietta, GA 30062
678-575-7754 Fax: 678-560-7185

Dear _____,

We are glad you have chosen our office for your Mental Health needs and look forward to your/your child's appointment on _____.

We ask that you take a few minutes and complete the following paperwork. We will need all this information for your initial appointment with Dr. Vincent Ho. If you have any past medical records, Psychological evaluations or pertinent information that would assist Dr. Ho in providing you with the best care, please bring it to our office prior to your appointment if possible.

If you need to change or cancel your appointment for any reason, please call at least 24 hours in advance of your appointment date. We do have a \$25 No Show or last minute cancellation fee that will be charged.

Please call our office if you have any questions.

Thank you,

Julie Fesefeldt, RN

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Welcome to our Practice!

Please 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

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**

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In order to provide the best & most efficient care please review & be aware of the following information and 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. Each person’s Mental Health coverage is different. Please confirm what company your mental health coverage is with, that Dr. Vincent Ho is in network, copay, deductible, # of visits allowed per year & if preauthorization is needed. covered **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/your child see a counselor/Psychologist along with Dr. Ho, **do not** schedule appointments on the same day. Most Insurance companies only pay for 1 mental health visit per day & allows you so many visits per year which includes both providers. Please know how many visits your plan will cover & keep track of those visits.
- ❖ **Missed or No Show Appointments** – Due to our growing patient census, we have a waiting list for people to see by Dr. Ho. Please be considerate and call **24 hours in advance** to cancel your appointment if you can not make it. 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.
- ❖ **Office Hours** – Dr. Ho & Julie are in the office **Monday – Thursday from 8:30 – 4:30 only**. During this time, please call **678-575-7754** and leave a message regarding concerns, questions or medication refills. Julie will return your call as soon as possible. **Any calls on Friday will be not be returned until the following Monday including refills.**
- ❖ **Phone Calls** – Scheduled phone appointments will be billed to your insurance company & you will be responsible for the copay or balance up to \$20 unless applied to your deductible & then you are responsible for the full amount applied. Self Pay patients will be charged \$20. Any other calls returned by Dr. Ho during & after hours may be charged as above per Dr. Ho’s discretion.
- ❖ **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 refill has 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** – There is a \$20 charge per letter request for Dr. Ho. We also ask that you allow 1 week for the letter to be prepared.

Thank you for taking time to review this information & helping us out with these few guidelines.

Responsible Party Signature _____ **Date** _____

**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 your 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 your 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** _____