Viet H. Ho, M.D., A Professional Corporation

PATIENT REGISTRATION

PATIENT NAME:_____SOCIAL SECURITY#:_____
(Mr/Mrs/Ms/Dr) LAST FIRST MI
DATE OF BIRTH: _____/_____/_____ AGE:_____ GENDER: M / F
ADDRESS:_____
STREET CITY STATE ZIP
HOME PHONE:(_____)_____ CELL PHONE:(_____)_____ WORK PHONE:(_____)_____
EMPLOYER:_____OCCUPATION:_____
EMERGENCY CONTACT PERSON:_____ PHONE:(_____)_____

IN CASE OF MINOR/DISABLED PERSON PLEASE LIST NAME OF RESPONSIBLE PARTY:

NAME:_____RELATIONSHIP:_____PHONE:(_____)_____
ADDRESS:_____
STREET CITY STATE ZIP

WHO MAY WE THANK FOR REFERRING YOU?_____
PRIMARY CARE PHYSICIAN:_____PHONE:(_____)_____
OPTOMETRIST/VISION CENTER:_____PHONE:(_____)_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____
SUBSCRIBER'S NAME:_____SUBSCRIBER'S DATE OF BIRTH:_____/_____/_____
SUBCRIBER'S ID# and/or SS#:_____GROUP#_____
SECONDARY INSURANCE COMPANY:_____
SUBSCRIBER'S NAME:_____SUBSCRIBER'S DATE OF BIRTH:_____/_____/_____
SUBCRIBER'S ID# and/or SS#:_____GROUP#_____

- Patients are required to present their insurance identification cards at the time of initial visit or when there is a change. If your insurance requires a REFERRAL or AUTHORIZATION, it is your responsibility to notify our office at the time of making your appointment. We will bill your insurance company as a courtesy for you.
- It is policy of our office to collect all COPAYMENTS at the time of each service. If a patient does not have proof of insurance, payment is required at the time of service.
- **AUTHORIZATION**: I hereby authorize Viet H. Ho, MD, PC to furnish information from my records to my insurance carriers and hereby irrevocably authorize the doctor all payment for medical services rendered. I understand that I am financially responsible for all the charges whether or not covered by insurance. Examples of services that may NOT be covered are routine eye exams, refractions, contact services and glasses. I have read and received a copy of the Notice of Privacy Practices.

PRINT NAME:_____

SIGNATURE:_____DATE:_____

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LIFETIME BENEFICIARY CLAIM AUTHORIZATION

I Request that payment of authorized _____ benefits,
(Primary Insurance Carrier)

and/or _____ benefits,
(Secondary/supplemental Insurance Carrier)

be made either to me or, on my behalf, to Viet H. Ho, M.D., P.C. for any services furnished to me by the physician/supplier.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to determine these benefits payable for related services. If item 12 of the HCFA-1500 claim form is completed, my signature authorizes the release of information to the insurer or agency shown. In assigned cases, the physician/supplier agrees to accept the charge determination of the carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. The co-insurance and deductible are based upon the charge determination of the carrier.

Signed:_____ Date: _____

Print: _____ ID/Group#: _____
Beneficiary (Patient) Name