Viet H. Ho, M.D.
A Professional Corporation
2299 Bacon St., Suite 11
Concord, CA 94520
T: 925-798-2020 F: 925-798-2004

Dear Patient:

Welcome to Viet H. Ho. M.D., A Professional Corporation. We are dedicated to providing you with the highest level of eye care service.

We ask you to kindly notify us 48 hours in advance if you are unable to keep your appointment. This will allow us sufficient time to schedule other patients to ensure that everyone has access to the medical care they deserve.

A NO-SHOW/LATE CANCELLATION FEE of **$150** will be charged.

Thank you and welcome.

Please bring the following items to your visit:

- Photo Identification
- All **CURRENT** Insurance Cards
- Insurance Authorized Referral *(*HMO plans*)*

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

FINANCIAL POLICY

PATIENTS WITHOUT INSURANCE

Our fees cannot always be determined in advanced, since they depend on services rendered. Full payment is due at the time of service.

PATIENTS WITH INSURANCE

We require that you show your current insurance cards at each visit. It is your responsibility to verify that we are within your health plan's network. You must have a current authorization/referral at the time of your visit. Co-payments and any outstanding account balances are due at the time of your visit. Should your health plan or medical group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

NO-SHOW/LATE CANCELLATION FEE

There will be a **$150.00** charge for any **No-show or same day cancellation** of office appointments without a 48 hour notice.

SURGERY CANCELLATION FEE

There will be a **$300.00** charge if you have to cancel or reschedule your surgery. This fee is waived if it is cancelled by your physician for medical reasons.

FORM PROCESSING FEE

There will be a $25.00 charge for the processing/completion of specialty letters, personal health forms, copies of tests, private or miscellaneous forms.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Signed:_____ Date: _____

Print: _____

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

PATIENT REGISTRATION

PATIENT NAME:_____SOCIAL SECURITY#:_____
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 each visit. If your insurance requires a AUTHORIZATION/REFERRAL, 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.
- **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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PATIENT MEDICAL HISTORY

PATIENT NAME:_____ Date: _____
DOB:_____/_____/_____

DRUG ALLERGIES? YES ☐ NO ☐ Please list:_____

MEDICATIONS currently taking: Blood thinners (plavix, coumadin, aspirin/NSAIDS) _____
_____
_____

PERSONAL MEDICAL HISTORY: Have you ever had the following diseases?

YES	NO		YES	NO	
☐	☐	Cataracts	☐	☐	Diabetes
☐	☐	Glaucoma	☐	☐	High blood pressure
☐	☐	Floaters	☐	☐	Blood disorder
☐	☐	Retinal detachment	☐	☐	Heart disease
☐	☐	Macular degeneration	☐	☐	Congestive heart failure
☐	☐	Dry/watery eyes	☐	☐	Cancer
☐	☐	Lazy eye	☐	☐	Cholesterol
☐	☐	Eye injury/surgeries	☐	☐	Migraines
☐	☐	Eye infection	☐	☐	Rosacea
☐	☐	Arthritis	☐	☐	Sleep apnea
☐	☐	Asthma	☐	☐	Stroke
			☐	☐	Thyroid problems

Other illnesses/injuries/hospitalizations:_____
List all SURGICAL procedures/dates:
_____
_____

FAMILY HISTORY: Has anyone in your family had:

☐ Cataracts	☐ Macular degeneration	☐ Heart Disease
☐ Glaucoma	☐ Diabetes	☐ Cancer
☐ Retinal detachment	☐ High Blood Pressure	☐ Thyroid

SOCIAL HISTORY: Current Occupation:_____ Marital Status:_____

Do you smoke? YES ☐ NO ☐ Packs/Day?_____
Do you drink alcohol? YES ☐ NO ☐ How often?_____
Do you use recreational drugs? YES ☐ NO ☐ How often?_____