HUMPHREY LU, MD
640-A Purissima Street
Half Moon Bay, CA 94019
Phone: (650)560-9137 Fax: (650)560-9138

Patient Information Name: ______________________ DOB: ____________ M/F

Home Address: ____

City: __________________________ State: ______ Zip Code: ____________

Home Phone: ____________ Cell Phone: ____________ Other Phone: ____________

Email: ____________________________E-mail Statements? Yes________No__________

Patient Insurance Information

Insurance Company: ____

Address: ____

Name of Insured: ________________ DOB: __________ Relationship: ____________

SSN: ____________________ Employer/Company: ________________________

Insurance ID #: ____________________________ Group #: ____________________

Responsible Party Information

Name: ____________________ DOB: __________ Relationship: ____________

SSN: ____________________ Employer: ________________________________

Address (If different): ____

Home Phone: ______________ Work Phone: ______________ Cell: ____________

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

You are responsible for the deductible, share of cost, copayment at time of visit, and any costs not a benefit of your plan. If you do not have insurance, your payment is due at the time of services rendered.
I authorize payment of medical benefits be made directly to the physician provider for services rendered.
I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accept assignment. I authorize use of information from this form to bill my insurance companies.

Guarantor Signature: ____ Date: ____________

AUTHORIZATION TO TREAT

I, ____________________, declare I am the guardian on record for ______________________,
and I consent to his/her treatment.

Signature: ____ Date: ____________________

Relationship to patient: ______________________________