Humphrey Lu, M.D.
319 Church Street
Half Moon Bay, CA 94019
650-560-9137

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: _____