RANDALL F. HUMPHREYS, M.D.

PATIENT INFORMATION
Please PRINT and FILL OUT COMPLETELY

| Patient Name: LAST | | MI |] | DOB: | | AC | iΕ |
|------------------------------|--|--------------|-------------|-------------|----------------|-------------|-----------------|
| ADDRESS: | FIRST | MI _CITY: | | | ST: | _ZIP:_ | |
| PHONE: HOME: () | Cell: ()_ | | Work: (|) | | ext | |
| SS# | MARITAL STATUS: | S M W | GENDER: | M F | RACE_ | | |
| EMAIL ADDRESS | | | | | | | |
| EMPLOYER or SCHOOL: | | 00 | CCUPATION_ | | | | |
| PRIMARY PHYSICIAN: | | | PHC | NE: (|) | | |
| REFERRED BY: | HOW DID YO | U HEAR ABO | UT US? Word | of Mouth, I | Phone Book, In | nternet, Pa | aper, TV, Other |
| HAVE WE EVER SEEN / ARE | | | | | | | |
| YES NO | | | | | | | |
| Adults: | | | | | | | |
| EMERGENCY CONTACT NA | ME | _CONTACT # | <u> </u> | RELA | TIONSHIP | | |
| If Child: Guardian's Name | | | SS# | | DOB:_ | / | / |
| CONTACT # | WORK# | RELATIONS | SHIP TO PAT | ENT | | | |
| ••••• | | CE INFORMA | ATION | ••••••• | •••••• | ••••• | ••• |
| PRIMARY: | INSURED NA | ME: | | | _DOB: | / | _/ |
| SECONDARY: | INSURED NA | ME: | | | _ DOB: | / | / |
| •••••• | المرادية ال | | | •••••• | •••••• | ••••• | ••• |

OFFICE POLICY

PLEASE READ AND SIGN BELOW

Payment is due and payable at the time services are rendered. As a courtesy, we will file your insurance for you. Any unmet deductible or co-pay is due at the time of visit.

I agree to be financially responsible for all charges not paid by my insurance. If my insurance fails to pay within 60 days, I understand that I will then be responsible for payment in full. Non payment of claims is between my insurance company and myself. If collection proceedings are required, I also agree to pay for the services rendered, as well as any other fees that may result from these proceedings.

I hereby authorize payment directly to Dr. Randall F. Humphreys for primary and secondary medical benefits, if any, otherwise payable to me for services described. I also authorize the release of medical information necessary to process my insurance claims.

I understand that I must give 24 hours notice if I am unable to keep my scheduled appointments. Otherwise, I agree to accept financial responsibility for time reserved. Missed appointment fee is \$25.00.

I further understand that Dr. Humphreys does not admit patients to the hospital. All patients should maintain a primary care physician for urgent care and for your general health care. If you need assistance in finding a primary care doctor, please let us know. I have read the above information and understand these policies.

| DATE: | /_ | / | SIGNATURE: | 0 | 1/14jt |
|-------|----|---|------------|---|--------|
| | | | _ | | _ |