



4428 Youree Drive
 Shreveport, LA 71105
 (318) 869-2297
 www.rapidreliefxperts.com

Thanks for choosing Rapid Relief Xperts Clinic. Please completely fill out this form to ensure the fastest and best healthcare service.

_____ Date

How will you be paying for today's services? ____cash ____credit card ____check
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Patient Name	Social Security Number
Date of Birth Age	Address, City, State, Zip
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation/Place of Employment
Insurance company name and policy number/ Primary (see your insurance card)	Insurance company name and policy number/ Secondary (see your insurance card)
_____	_____
_____	_____
Effective date: _____	Effective date: _____

If the patient is covered under the policy of a spouse, parent, or legal guardian, please tell us about them.

Policy Holder's Name	Social Security Number
Date of Birth Sex	Address, City, State, Zip
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation/Place of Employment
Policy Holder's Relationship to Patient	

Referral Source - Please Circle TV Newspaper Phone Book Health Unit Mail Family/Friend Website Sign Physician: Dr. _____ School: _____
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AGREEMENT TO PAY: In consideration for the services rendered and to be rendered by Rapid Relief Xperts, LLC to the below-captioned patient, I (we) agree to pay Rapid Relief Xperts, LLC for all services and charges as are ordered by the attending provider in accordance with the terms and policies of Rapid Relief Xperts. I (we) further agree and guarantee that in the event the account is not paid in accordance with the arrangements made, to pay collection costs, including court costs, reasonable attorney fees and interest from the date of demand, if this account is placed for collection. Also, I (we) hereby acknowledge that Rapid Relief Xperts, LLC cannot assume responsibility for money, clothing, bridgework, dentures, eyeglasses, jewelry, credit cards, or any other personal items kept in my possession.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign to Rapid Relief Xperts, LLC and the attending provider, expenses or other surgical or treatment expenses and benefits which are due to become due to me as a result of medical services to the patient listed below. I hereby authorize the payments to be paid directly to Rapid Relief Xperts, LLC for any services or charges not covered by my insurance carrier or out-of-state workers compensation claim.

CONSENT TO TREATMENT: I hereby voluntarily consent to medical care to include diagnostic procedures and medical treatment judged necessary by the provider or his designee. I acknowledge that no guarantees have been made to me as a result of this treatment. In addition to all other consents given elsewhere in this document, I specifically consent to medical procedures and tests necessarily performed upon me to aid and assist in the diagnosis and treatment of my child. These tests may include tests for the presence of alcohol or controlled substances.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Rapid Relief Xperts, LLC and all providers involved with my care to release information from my medical records to any person, corporation, or agency which is legally responsible or which Rapid Relief Xperts, LLC had good cause to believe is legally responsible, for processing and/or paying all or any part of Rapid Relief Xperts's professional charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize Rapid Relief Xperts, LLC or any provider involved with my care to release information to any provider or health care facility to which I may be transferred for further medical care.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES: The undersigned hereby acknowledges and certifies the he/she received a copy of Rapid Relief Xperts's Notice of Privacy Practices.

_____ Relationship: _____ Date: _____
Signature of Patient (or Parent/Guardian for minor)

_____ Date: _____
Signature of Spouse (if applicable)

_____ Date: _____
Witness (Rapid Relief Xperts Employee)



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Name: _____

Age: _____

Last Menstrual Period: _____

Regular Family Doctor: _____

Describe the signs & symptoms that brought you to the clinic today (e.g., runny nose, cough)?

How long has this illness been going on? _____

During your illness have you experienced any of the following:

Fever Nausea Vomiting Diarrhea Decreased appetite Wt Loss
Joint aches Muscle aches Dizziness Pain Rash

Do you have any **allergies** to **medications** or to **food**? If so, please list your allergies & describe your allergic reaction (e.g., penicillin causes a rash).

Do **you** or a **family member** have any health problems? Circle all that apply:

Allergies Asthma Arthritis Bronchitis Cancer Diabetes

Chronic Back Pain Heart Disease High Blood Pressure

High Cholesterol Heart Attack Kidney Disease Stroke

What surgeries have you had & when? _____

List medications you take on a daily basis. _____

Do you smoke cigarettes? No

Yes ½ pack/day 1 pack/day 1.5 pack/day more

Do you use any illicit drugs? No

Yes marijuana cocaine heroine ecstasy other _____

Do you drink alcohol? No

Yes rare occasional 1-2 drinks/day excessive