GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS

ALL CHARGES FOR SERVICES RENDERED INCLUDING CO-PAYS ARE DUE AT THE TIME OF SERVICE.
(PLEASE INITIAL ALL BELOW)

I AM RESPONSIBLE FOR VALUE RECEIVED AND PROMISE TO PAY RAPID MD LLC FOR ALL CHARGES INCURRED AND TO BE INCURRED FOR SERVICES RENDERED. THE UNDERSIGNED UNDERSTANDS THAT RAPID MD LLC WILL FILE THE PATIENTS INSURANCE CLAIMS AS A COURTESY TO THE PATIENT AND AUTHORIZES RAPID MD LLC TO RELEASE ANY AND ALL INFORMATION NECESSARY TO PERFECT SAID INSURANCE CLAIMS AND OR TO COLLECT ANY BALANCE DUE TO RAPID MD LLC. HOWEVER, IT IS UNDERSTOOD AND AGREED THAT THE PATIENT AND OR THE UNDERSIGNED IS RESPONSIBLE FOR PERFECTING AND FOLLOWING UP ON ANY INSURANCE CLAIMS

_____AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: ANY AND ALL INSURANCE CHECKS THAT MAY GO DIRECTLY TO THE PATIENT MUST BE SIGNED OVER TO RAPID MD LLC FOR PAYMENT FOR SERVICES RENDERED. FAILURE TO DO THIS WILL RESULT IN THE PATIENT RECEIVING A BILL FOR SERVICES. I HEREBY AUTHORIZE PAYMENT FOR MEDICAL SERVICES PROVIDED DIRECTLY TO RAPID MD LLC PHYSICIAN. IF I SHOULD RECEIVE ANY INSURANCE PAYMENTS I AM TO SIGN THE CHECK OVER TO RAPID MD LLC.

PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT/GUARDIAN: _____

GENERAL MEDICAL HISTORY

PATIENT'S NAME: _____

AGE _____ DATE OF BIRTH _____/_____/_____ SEX ( ) M ( ) F

PLEASE ANSWER THE FOLLOWING QUERSTIONS. IF YOU DO NOT KNOW THE ANSWER, PLEASE CIRCLE THE QUESTION.

PLEASE LIST ALL HOSPITALIZATIONS, SURGERIES AND RELATED DATES

_____

_____

DRUG ALLERGIES: _____

MEDICATIONS YOU ARE CURRENTLY TAKING? _____

PLEASE CHECK IF YOU, YOUR PARENTS, SIBLINGS OR CHILDREN HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:
( ) HEART DISEASE ( ) HIGH BLOOD PRESSURE ( ) CANCER ( ) DIABETES ( ) STROKE

IF YES, PLEASE LIST RELATIONSHIP, _____

PLEASE LIST ANY OTHER FAMILY ILLNESS, _____

DO YOU CURRENTLY SMOKE? ( ) YES ( ) NO, IF NO ARE YOU A FORMER SMOKER? ( ) YES ( ) NO

IF YES, HOW MANY PACKS PER DAY? _____

DRINK ALCOHOL? ( ) DAILY ( ) WEEKLY ( ) OCCASIONALLY ( ) NEVER

HAVE YOU EVER BEEN DIAGNOSED WITH ANY IF THE FOLLOWING?

YES / NO

( ) ( ) EYE TROUBLE GLAUCOMA, CATARACTS OR SURGERY
( ) ( ) WEARS GLASSES OR CONTACTS
( ) ( ) DIFFICULTY HEARING SPEECH
( ) ( ) RINGING IN EARS
( ) ( ) FREQUENT OR SEVERE HEADACHES
( ) ( ) DIZZINESS, VERTIGO OR BALANCE PROBLEMS
( ) ( ) SEVERE SHORTNESS OF BREATH
( ) ( ) ASTHMA
( ) ( ) HAY FEVER REQUIRING MEDICINE OR SHOTS
( ) ( ) CHRONIC COUGH OR COLDS
( ) ( ) BRONCHITIS OR EMPHYSEMA
( ) ( ) TUBERCULOSIS
( ) ( ) RIB FRACTURES
( ) ( ) HEART MURMURS
( ) ( ) HIGH BLOOD PRESSURE
( ) ( ) HEART ATTACK
( ) ( ) SEVERE PALPATIONS OR IRREGULAR HEARTBEAT
( ) ( ) CHEST PAINS
( ) ( ) HEPATITIS, LIVER TROUBLE /IRREGULAR HEARTBEAT
( ) ( ) PERSISTENT INDIGESTION OR REFLUX
( ) ( ) COLITIS OR RECURRENT
( ) ( ) KIDNEY TROUBLE OR KIDNEY STONES
( ) ( ) RECURRENT URINARY TRACT INFECTIONS
( ) ( ) CANCER
( ) ( ) BREAST DISEASE

YES/ NO

( ) ( ) FREQUENT CHILLS, FEVER OR NIGHT SWEATS
( ) ( ) MUSCLE OR JOINT PROBLEMS
( ) ( ) ARTHRITIS
( ) ( ) KNEE PAIN
( ) ( ) BROKEN OR FRACTURED BONES
( ) ( ) EASY BLEEDING OR BRUISING
( ) ( ) SWELLING OF ANKLES OR VARICOSE VEINS
( ) ( ) BRAIN INJURY OR STROKE
( ) ( ) SEIZURE, CONVULSIONS, EPILEPSY OR
( ) ( ) PARALYSIS
( ) ( ) SKIN DISEASE OR CHANGES IN MOLE
( ) ( ) DEPRESSION OR MENTAL ILLNESS
( ) ( ) PRIOR DRUG OR ALCOHOL TREATMENT
( ) ( ) WEAR SPECIAL MEDICAL DEVICES IMPLANTS
( ) ( ) RECENT WEIGHT GAIN OR LOSS
( ) ( ) CONCUSSIONS
( ) ( ) HERNIA
( ) ( ) ANEMIA
( ) ( ) DIABETES

OTHER MEDICAL ILLNESS?

_____

IF YES TO ABOVE PLEASE IDENTIFY AND DESCRIBE____

_____