Silver Creek Family Practice
302 Pitts St, Morganton, NC 28655
P:828.608.2016 F:828.608.2029

Patient Registration Form

- Full Name: Date of Birth
- Sex: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say Social Security Number
- Address
- City: State: Zip: Phone Number: **(Text Reminders)**
- Email Address **(NEEDED FOR YOUR PATIENT PORTAL AS ALL REFILL REQUEST NEED TO GO THROUGH YOUR PATIENT PORTAL)**
- Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other:
- Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to say

Insurance Information & Photo ID (Must provide an active insurance card & photo ID at the time of visit or self-pay)

Emergency Contact

- Name:
- Relationship:
- Phone Number:

Pharmacy Name: **Pharmacy Number:**

Consent to Disclose Protective Health Information (HIPAA)

By signing below, I hereby authorize Silver Creek Family Practice to disclose my protected health information to the following family members and/or friends:

Name: **Relationship to Patient:** **Phone:**

Name: **Relationship to Patient:** **Phone:**

By signing below, I acknowledge that I have either received a copy of been advised of the Notice of Privacy Practices and of how health information about me may be used and disclosed by Silver Creek Family Practice staff & providers, and how I may obtain access to and control the information.

I authorize Silver Creek Family Practice to send me text and email reminders. By signing below, I authorize Silver Creek Family Practice to leave voicemails, send emails with updates on labs/ test results or any other information pertaining to my medical history. A written letter must be provided to Silver Creek Family Practice if you wish to opt out of these services and only wish to be contacted via "phone call".

Consent for Treatment, I authorize Silver Creek Family Practices personnel to perform on me the care necessary to diagnose and treat any condition as directed by my medical provider. I understand I have the right to be informed by my medical provider of the nature, purpose and any risk of any proposed operation or procedure and any available alternative method of treatment. Patient signature consents to all aspects of this complete package.

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS I authorize Silver Creek Family Practice to furnish all necessary medical information relating to this treatment to any insurance company, governmental, or charitable agency and their agents, and any professional review organization with whom I may have insurance coverage or who may be assisting in payment of my medical expenses. I also authorize Silver Creek Family Practice to release any medical information to my referring physician, primary care physician, treating physician, consulting physicians, and hospital-based physicians, as well as, to any licensed provider, health care agency, or medical or nursing facility to which I am referred or transferred for further medical care. This authorization shall remain in effect until the day you revoke this consent. I am aware that I may revoke this consent with a written request by me at any time.

ASSIGNMENTS OF INSURANCE BENEFITS I authorize payment of any insurance benefits to be made directly to Silver Creek Family Practice. I authorize and direct all insurance entities to furnish Silver Creek Family Practice with all information regarding my benefits, status of claims, reasons for non-payment and other information deemed necessary by Silver Creek Family Practice.

FINACIAL AGREEMENT For all services and or supplies not covered or deemed medically necessary by my health plan, I agree to accept financial responsibility and to pay Silver Creek Family Practice directly out of pocket. I understand that full payment is due within thirty days of billing or as otherwise arranged by mutual consent of both parties. I understand that payments, co-pays, and co-insurance for services rendered is to be collected prior to being checked in. I understand that payment for services rendered will be collected in full prior to checking in if I do not present a copy of my current insurance card. PRIVACY I have been provided with the opportunity to review the Notice of Privacy Practices (HIPPA) which describes how Silver Creek Family Practice will use and disclose my information and informs me of my rights relating to my information. Silver Creek Family Practice also participates in an electronic health information exchange which allows the sharing of information for appropriate purposes.

ELECTRONIC PRESCRIBING PROGRAM ePrescribe Program - ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. Pulled medication history and transactions provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

CONTROLLED SUBSTANCE AGREEMENT Controlled Substance medications are used to relieve symptoms, improve function and promote the ability to work. Due to their high potential for addiction and misuse, these medications are controlled and closely monitored by local, state and federal government agencies. If these medications fail to achieve the stated objectives, they will not be continued. I "the patient" am aware that it is my responsibility to keep up with my medications. If my prescription is lost, misplaced or stolen, it will not be replaced. I will not offer, give, or sell my Controlled Substance medication to any individual. I will not request or accept Controlled Substance medications from any individual or other physicians. I will not use street drugs such as marijuana, cocaine, methamphetamines, etc. I consent to having random pill counts and or urine screenings at the request of my provider at any given time. If I violate any of the conditions listed, my medical care at Silver Creek Family Practice will be terminated and I will be dismissed from the practice.

SILVER CREEK FAMILY PRACTICE CONSENT AND AUTHORIZTION FORM CONTINUED APPETITE SUPPRESSANTS I understand my treatment may involve, but not limited to, the use of appetite suppressants in patients with abnormal weight, for more than 12 weeks and in higher or lower doses than stated in the appetite suppressant labeling. I understand that the use of appetite suppressants in patients with BMI less than 27, for more than 12 weeks and in higher doses than stated in the appetite suppressants labeling involves some risks. The more common risks include, but are not limited to nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious and fatal risks include primary pulmonary hypertension and valvular heart disease. I understand that continuing appetite suppressants will depend on my progress in weight loss and weight maintenance.

PATIENT RESPONSIBILITIES (APPOINTMENT TIME, NO SHOW, CANCELLATION AGREEMENT) Among other responsibilities, I understand that I am expected to keep and be on time for my medical appointments. I understand that if I am more than 10 minutes late for my scheduled appointment, I will be marked as a "no-show" and be asked to reschedule my appointment. I understand that once I obtain one "no-show" and or "same day cancellation" I will be charged a **$25 dollar no show** fee that must be collected at the time of my next appointment prior to being seen. I understand that I may be dismissed from the practice for repeated "no-shows" and or "cancellations".

PRESCRIPTION REFILL REQUEST I understand that any refill request will be sent in during open business hours only. I understand that these hours of operation are Monday through Thursday from 8am to 7pm. I understand that any refill request sent through my patient portal will not be responded to on any day that the practice is closed. This includes Friday, Saturday, Sunday, and all holidays that the practice is closed on. I understand that it is my responsibility to keep up with my refills and maintain requesting refills prior to running out of my medication. I understand that it is my responsibility to utilize my patient portal for refill request as this is the most effective way of obtaining a refill. I understand that if requesting a refill via, patient calling or pharmacy faxing, these requests may take up to 72 hours to respond to due to the high volume of in office patient care throughout the day.

FINANCIAL RESPONSIBILITY AGREEMENT The Silver Creek Family Practice Weight Management Program is an elective service and is not considered medically necessary under many insurance benefit plans. Participation in this program is voluntary. As a courtesy only, Silver Creek Family Practice may submit claims to the patient's primary insurance carrier. Silver Creek Family Practice does not bill secondary insurance for services related to the Weight Management Program. By signing this agreement, the patient acknowledges and agrees to the following: 1. The Weight Management Program is elective and may not be covered by insurance. 2. Submission of claims to primary insurance is a courtesy and does not constitute a guarantee of coverage or payment. 3. Silver Creek Family Practice will not bill secondary insurance for these services. 4. Silver Creek Family Practice will not dispute, appeal, or resubmit denied claims related to the Weight Management Program. 5. If the primary insurance carrier denies the claim, applies the charge to deductible, pays less than the full amount billed, or determines the service is not medically necessary, the patient agrees to be fully financially responsible for: a. The established self-pay program fee; or b. Any unpaid balance remaining after insurance processing. 6. If insurance reimbursement is less than the established self-pay fee for the program, the patient agrees to pay the difference. 7. Any unpaid balance is due upon notification. Accounts not paid as agreed may be subject to collection action in accordance with North Carolina law. The patient agrees to be responsible for any reasonable costs of collection, including attorney's fees, to the extent permitted by law. The patient understands that verification of benefits is not a guarantee of payment and that ultimate financial responsibility rests with the patient. By signing below, the patient confirms that they have read, understand, and agree to the terms of this Financial Responsibility Agreement and accept full financial responsibility for all charges associated with participation in the Silver Creek Family Practice Weight Management Program.

CREDIT CARD ON FILE AUTHORIZATION I authorize Silver Creek Family Practice to securely store my credit /debit card information through its payment processing system for payment of amounts that I am financially responsible for. My card information will be stored securely through Swipe Simple and will not be written on or maintained in my paper medical record. I authorize Silver Creek Family Practice to charge the card on file for amounts including, but not limited to: copayments, coinsurance, deductibles, outstanding patient balances, self-pay services, products and all other amounts determined to be my responsibility after my insurance claim has been processed.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

SCFP Patient Medical History & Screening Questionnaire

Print Name _____ **Date of Birth** _____

☐	**Medical History**	☐	
☐	Seasonal Allergies	☐	High Blood Pressure
☐	Arthritis	☐	High Cholesterol
☐	Asthma-COP	☐	Kidney Disease
☐	Cancer (Wh	☐	Liver Disease or Hepatitis
☐	Chronic Pain (Location)	☐	Stroke
☐	Depression	☐	Seizures
☐	Diabetes	☐	Sleep Apnea
☐	Glaucoma or Cataracts	☐	Thyroid Disease
☐	Acid Reflux	☐	Bladder or Urinary Problems
☐	Stomach Ulcers		Sexually Transmitted Disease
	Heart Disease		

Allergies & Medication Reactions

☐	No Known Allergies			
☐	Latex or Dye			

Surgical

☐	Appendix	☐	Bladder	☐	Joint Replacement
☐	C-Section	☐	Back	☐	Other
☐	Cosmetic	☐	Breast		
☐	Gastric Bypass	☐	Tubal Litigation		
☐	Hysterectomy/Total or Partial	☐	Gallbladder		
☐	Tonsillectomy	☐	Hernia		

OBGYN: Total number or Pregnancies: _____ Total number of Miscarriages: _____ Total number of Abortions: _____

Have you ever had an abnormal PAP smear: Yes ☐) No (☐ IUD: Yes ( ) No ( )

Family History (MARK "M" FOR MOTHER & MARK "F" FOR FATHER)

☐	Cancer? What kind	☐	Depression	☐	Smoker/Drinker
☐	Heart Disease	☐	Diabetes	☐	Anxiety
☐	Kidney Disease	☐	High Blood Pressure		
☐	Obesity	☐	Asthma/COPD/ Emphysema		
☐	Stroke	☐	Psychiatric Illness		
☐	Thyroid Disease	☐	Seizures		

Depression Screening (PHQ-9) box (0-3) (0 none to 3 always)

• Little interest or pleasure in doing things | ☐ | ☐ | ☐ ☐

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- Feeling down, depressed, or hopeless | ☐ | ☐ |
- Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ |
- Feeling tired or having little energy | ☐ | ☐ |
- Poor appetite or overeating | ☐ | ☐ |
- Feeling bad about yourself — or that you are a failure or have let yourself or your family down | ☐ | ☐ |
- Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ |
- Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ |
- Thoughts that you would be better off dead, or thoughts of hurting yourself | ☐ | ☐ |

MDQ Screening Yes (first box) No (second box)

1. You felt so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | ☐ | ☐ |
2. You were so irritable that you shouted at people or started fights or arguments? | ☐ | ☐ |
3. You felt much more self-confident than usual? | ☐ | ☐ |
4. You got much less sleep than usual and found you didn't really miss it? | ☐ | ☐ |
5. You were more talkative or spoke much faster than usual? | ☐ | ☐ |
6. Thoughts raced through your head or you couldn't slow your mind down | ☐ | ☐ |
7. You were so easily distracted by things around you that you had trouble concentrating or staying on track? | ☐ | ☐ |
8. You had much more energy than usual? | ☐ | ☐ |
9. You were much more active or did many more things than usual? | ☐ | ☐ |
10. You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ☐ | ☐ |
11. You were much more interested in sex than usual? | ☐ | ☐ |
12. You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ☐ | ☐ |
13. Spending money got you or your family into trouble? | ☐ | ☐ |

TOBACCO USE

Current use: ☐ Yes ☐ No

If yes: ☐ Daily ☐ Occasional

Type: ☐ Cigarettes ☐ Vape ☐ Smokeless ☐ Other:

Amount: ____ /day

Years: ____

Former ☐ Yes ☐ No

Quit date: ____

Interested in quitting:

☐ Yes ☐ No ☐ Not sure

AUDIT-C (Alcohol)

1. Frequency:

☐ Never (0) ☐ Monthly (1)

☐ 2–4/mo (2) ☐ 2–3/wk (3) ☐ 4+/wk (4)

2. Drinks/day:

☐ 1–2 (0) ☐ 3–4 (1)

☐ 5–6 (2) ☐ 7–9 (3) ☐ 10+ (4)

3. 6+ drinks:

☐ Never (0) ☐ <Monthly (1)

☐ Monthly (2) ☐ Weekly (3) ☐ Daily (4)

To the best of my knowledge, the above information is accurate and complete. I understand that the above information is crucial to my medical care and can be used for billing my insurance. I will not hold any provider or staff member at Silver Creek Family Practice responsible for an error or omissions that I may have made in completing this form.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____