

PATIENT INFORMATION

Child's Full Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Social Security Number: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

PARENT / LEGAL GUARDIAN INFORMATION

Parent / Guardian #1 Name: _____ Relationship: _____ Date of Birth: _____

Address: ☐ Same as Patient If different: _____ Cell Phone: _____

Parent / Guardian #2 Name: _____ Relationship: _____ Date of Birth: _____

Address: ☐ Same as Patient If different: _____ Cell Phone: _____

CUSTODY / LEGAL INFORMATION Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Other: _____

Custody agreement or court order affecting medical decisions? ☐ No ☐ Yes / If yes, provide a copy to the office.

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

MEDICAL, SCHOOL, AUTHORIZATION & CONSENT

PEDIATRIC MEDICAL INFORMATION

ALLERGIES Medication, food, latex, or environmental allergies? ☐ No ☐ Yes If yes, list allergy and reaction:

CURRENT MEDICATIONS List prescriptions, over-the-counter medications, vitamins, and supplements

MEDICAL CONDITIONS Significant medical conditions? ☐ No ☐ Yes

If yes, explain: _____

SURGERIES / HOSPITALIZATIONS Previous surgery or hospitalization? ☐ No ☐ Yes

If yes, explain and include dates when known: _____

SCHOOL / CHILDCARE INFORMATION School / Daycare: _____ Grade: _____

AUTHORIZED PERSONS Consent to Disclose Protective Health Information (HIPAA)

Pediatric From Silver Creek Family Practice 302 Pitts St Morganton NC 28655 828.608.2016

I authorize the following individuals to bring my child to appointments and/or consent to routine medical treatment when I am unavailable. 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: Phone:

Name: Relationship: 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".

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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.

Parent / Legal Guardian Name (PRINT NAME): _____

Signature: _____

Relationship to Child: _____ **Date:** _____

Witness Signature: _____ **Date:** _____