



Silver Creek Family Practice  
110 E Main St, Morganton, NC 28655  
T: 828-608-2016  
F: 828-608-2029  
Lindsey Michaels, FNP-C  
Christy Biggerstaff, FNP-C

## Patient Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### Guarantor Information (Primary Insurance Policy Holder Information)

Guarantor Name: \_\_\_\_\_

Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_

Please select **only one** of the following for today's visit. Due to insurance we can only address Weight or Family at the time of your visit. We apologize for any inconvenience. Thank you, SCFP Providers & Staff.

Family Practice    Weight Management    Sick Visit / Walk In









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**Acknowledgement of Receipt of Privacy Practice (HIPAA)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

I have been presented with a copy of this "Notice of Privacy Practices."

Yes  No I have been offered/received information about my rights and responsibilities as a patient or the legal representative of the patient.

**Preferred method of Contact:**

Phone(text) \_\_\_\_\_  Written   
 Email \_\_\_\_\_

**Patient Questionnaire** –Please list the family members or other persons, and their relationship to you whom we may inform about your general medical condition and your diagnosis.

Authorized Person	Relationship	Phone Number

**Contacts in Case of an Emergency:**

Authorized Person	Relationship	Phone Number

Yes  No Can confidential messages be left on your answering machine or voicemail?  
**\*\* I am fully aware that a cell phone is not a private and secure line. \*\***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_





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### Consent and Authorization Form

#### 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 risks of any proposed operation or procedure and any available alternative methods of treatment.

#### AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

I authorize Silver Creek Family Practice to furnish 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 for a period of three hundred and sixty-five (365) days from the date of execution of this document unless sooner revoked by me.**

#### 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 claim, reasons for non-payment and other information deemed necessary by Silver Creek Family Practice.

#### FINANCIAL 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. I understand that full payment is due within thirty (30) days of billing or as otherwise arranged by mutual consent of both parties.

#### PRIVACY

I have been provided with the opportunity to review the *Notice of Privacy Practices* document 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. I agree that my information will be included in this electronic network unless I choose to opt-out.

#### PATIENT RESPONSIBILITIES

Among other responsibilities, I understand that I am expected to keep and be on time for my medical appointments, and that repeated late arrivals or no-shows on my part may ultimately result in discharge from the practice.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Signature: \_\_\_\_\_  
Witness \_\_\_\_\_ Date: \_\_\_\_\_





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### No Show/ Cancellation Policy

Thank you for trusting your medical care to Silver Creek Family Practice. When you schedule an appointment with Silver Creek Family Practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- **When a patient No-Shows for an appointment three (3) times, a patient cancels without a 24-hour notice three (3) times, and has a combination of three (3) no-shows and or cancellations without 24-hour notice within a three (3) month period the patient will be charged a \$25.00 fee.**

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Billing Department, who may be able to waive the No Show fee. You may contact Silver Creek Family Practice 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

**Office Numbers: 828-608-2016 or 828-514-6817**

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

\_\_\_\_\_  
Printed Name & Date

\_\_\_\_\_  
Signature

