HIGH COUNTRY community health

Chambers Program Registration Form *(Please Print)*

Name: _____

Responsible Party: _____ **Relationship to Patient**: _____
(If under 18)

Number of Dependents: _____

Address: _____

City/State/Zip: _____

Best Phone number to reach you: (___) _____ **2nd Phone:** (___) _____

Avery County Chamber Employer:

_____

Employed Since: _____ **Job/Occupation:** _____

Email: _____

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****Please bring photo identification.**

TREATMENT/OPERATION/PAYMENT AGREEMENT WITH HIGH COUNTRY COMMUNITY HEALTH

I authorize **High Country Community Health** to provide me and/or my family with medical care. I authorize assignments of insurance benefits for medical care to be paid to **High Country Community Health**.. I understand that it is my responsibility to pay for the medical care provided by High Country Community Health at the time of visit. I attest that all of the information I have provided is correct.

Signature: _____ Date: _____
(Patient or responsible party if under 18)

Return by fax: 828-737-0321, or bring to our office at 448 Cranberry St, Newland, NC 28657
Visit our website: http://www.highcountrycommunityhealth.com/