PIRATE
PEDIATRICS
118 Oakmont Drive
Greenville, NC 27858
252.364.8790
www.piratepediatrics.com

Welcome to Pirate Pediatrics! We are here to provide you and your child with quality and compassionate care. We see children and adolescents from birth to 18 years of age. Thank you for choosing us to care for your child. We look forward to many years of developing a relationship and watching your child grow into a healthy, responsible adult.

Enclosed you will find our new patient information. Please complete and submit each of the following documents to our office staff prior to or at the time of your first visit:

- ☐ **Release of Records:** It is important that we obtain copies of your child's previous medical records from those who have treated your child in the past. Please complete a separate release form for each doctor your child has seen.
- ☐ **Patient Registration Form:** This form provides your address and phone number, emergency contacts, and insurance information.
- ☐ **Health History Form:** Provides information about your child's past medical history.
- ☐ **E-mail Consent Form:** We will send your appointment reminders and any pertinent forms via email (Ages and Stages Questionnaires, Teacher and Parent Vanderbilts, etc). Please complete the information and bring with you to your visit to decrease your wait time in the office.
- ☐ **Financial Policy:** Please sign and return this form to the office staff.
- ☐ **Office Policies and Agreement**
- ☐ **Notice of Privacy Practices**

Please be sure to bring your insurance card(s) and required co-payment (if any) to the appointment.

Also, be sure to visit the website, www.piratepediatrics.com. Our website provides you with information on how to schedule appointments, billing, refill requests, and more.

We are also on Facebook as Pirate Pediatrics, PA. We post medical tips and social information. We would love for you to join us.

Once again, welcome to Pirate Pediatrics. Should you have any questions, please do not hesitate to contact us at (252) 364-8790.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NAME: ____ DATE OF BIRTH: ____ /____ /____
(First) (Middle) (Last) (mm) (dd) (yyyy)

I authorize ________________________ ___________________**to release the medical information selected below to:**
(Name of health care entity) (City and State)

PIRATE PEDIATRICS, PA

Please check all that apply:
[ ] Complete medical record (patient histories, office notes, lab reports/results, radiology studies and diagnostic reports, films, referrals, consults, billing records, insurance records, records sent by other health care providers)
[ ] Newborn metabolic screen and birth records
[ ] HIV-related information
[ ] Mental health records
[ ] Alcohol/drug treatment

I understand that the records above are protected by the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

Signature:____ Date:_____ / _____ / _____
(Patient's Legal Guardian)

Signature:____ Date:_____ / _____ / _____
(Witness)

This authorization expires once the records indicated have been obtained.

NEW PATIENT REGISTRATION

NAME: ____________________________________ **DATE OF BIRTH: ____ /____ /____**
(First) (Middle) (Last) (mm) (dd) (yyyy)
Sex: [ ] male [ ] female SSN:____________________

Mother/Guardian:____ DOB:___/___/___ SSN:___________________
Address:____ Cell/Home phone:______________________
City/State/Zip:_______________________________________ Work phone:____________________________

Father/Guardian:____ DOB:___/___/___ SSN:___________________
Address:____ Cell/Home phone:______________________
City/State/Zip:_______________________________________ Work phone:____________________________

Sibling(s) Name/DOB/Gender:____
____

Children live with: [ ] Mother [ ] Father [ ] Guardian____
Emergency Contact Person:_____________________________ Relation:_________________ Phone:____________
Party Responsible for Payment of Medical Services: [ ] Mother [ ] Father [ ] Both [ ] Guardian
How did you hear about us?____

INSURANCE INFORMATION:

Primary:_________________________________ Policy #:______________________ Group #:____________________
Secondary:_______________________________ Policy #:______________________ Group #:____________________

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT:

I authorize **Pirate Pediatrics, P.A./Dr. Caroline Morgan** to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to **Pirate Pediatrics, P.A.** for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of the authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot by given unless my child is accompanied by me or by one of the following individuals:____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluid in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature__________________________________Relationship______________Date________________

NEW PATIENT HEALTH INFORMATION

NAME: ______________________________________ **DATE OF BIRTH:** ____ /____ /____
(First) (Middle) (Last) (mm) (dd) (yyyy)

Race: [] American Indian [] Asian [] African American [] White [] Prefers not to answer
Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Prefers not to answer
Preferred Language: [] English [] Spanish [] Other _____ [] Prefers not to answer

MEDICATION ALLERGIES:
____
____

BIRTH HISTORY:

[ ]vaginal [ ]c-section for _______________ Prenatal Care: [ ]yes [ ]no
Complications during pregnancy: [ ]no [ ]yes; Please explain:____
Tobacco/alcohol/ drugs during pregnancy: [ ]no [ ]yes ; Please explain:____
Weeks at delivery: _________ Birth Weight:________ Birth Length:_________
Complications during stay in nursery: [ ]no [ ]yes; Please explain:____
Complications during first two weeks of life: [ ]no [ ]yes; Please explain:____

PAST MEDICAL HISTORY:

Please check any of the following your child has experienced in the past and indicate the age it began/occurred.

	√	Age		√	Age		√	Age
Asthma			Diabetes			Scoliosis/back problems		
Bedwetting/daytime wets			Emotional problems			Seizures		
Bladder/kidney infection			Frequent ear infections			Skin problems		
Broken bones			Hearing problems			Sleeping problems		
Chicken pox			Heart problems/murmur			Speech difficulties		
Concussion			Learning problems			Vision problems		
Other:			Other:			Other:		

Current Medications:

Name of Medication	Dose	Times per day	Reason for taking	When began taking

Hospitalizations/Surgeries: Please list any surgeries or overnight stays at the hospital.

Date (approx)	Age	Hospital Name	City, State	Reason for hospital stay/surgery/procedure

Please list any known allergies: ____
Please list any other significant health history issues: ____

FAMILY HEALTH HISTORY:

Have your child's relatives had any of the following illnesses? If so, please indicate the relationship of the individual to the patient, using the key below.

M=mother **F**=father **B**=brother **S**=sister
MGM=maternal grandmother **MGF**=maternal grandfather **MA**=maternal aunt **MU**=maternal uncle
PGM=paternal grandmother **PGF**=paternal grandfather **PA**=paternal aunt **PU**=paternal uncle
MC=maternal cousin **PC**=paternal cousin

	Relationship		Relationship		Relationship
Alcohol abuse		Drug abuse		Learning disability	
Asthma		Heart attack (<65 yrs)		Mental illness/suicide	
Cancer		Heart problems (other)		Seizures	
Diabetes (adult onset)		High blood pressure		Stroke	
Diabetes (child onset)		HIV/AIDS		Sudden unexplained death	
Deafness		Kidney disease		Thyroid disease	
Other:		Other:		Other:	

IMMUNIZATION HISTORY / NEWBORN SHOTS:

Pirate Pediatrics values the importance of vaccines and promotes their ability to prevent disease. We follow the US Center for Disease Control and Prevention (CDC) schedule for vaccines.. All patients must be compliant with the CDC vaccination schedule (or catch-up schedule). Please fill out the vaccinations your child has received at the present time:

Vaccine	Last Date Administered
Hepatitis B	
Vitamin K	
Erythromycin (eye ointment)	

Form Completed By:______________________________________ **Relationship to Patient:**____________________

Signature:____ **Date:**_____ / _____ / _____

Welcome to Pirate Pediatrics! We are excited to have you as a new patient. Thank you!!

E-Mail/Patient Portal Consent Form

Please initial each section to document your agreement.

_____I understand e-mail can be intercepted and read by individuals other than those for whom I intend the message, even if I put the correct e-mail address on it.

_____I understand e-mail is not appropriate for urgent, emergent, or sensitive issues.
I understand that e-mail sent from an employer-provided e-mail address may be read, saved, and archived by my employer.

_____I understand e-mail messages can be subpoenaed as evidence in court cases.

_____I understand Pirate Pediatrics saves and archives all ingoing and outgoing e-mail messages to and from the practice. I understand these messages are treated with the same confidentiality as the rest of the medical record.

_____I understand other staff members of Pirate Pediatrics might read, save, or archive my e-mail message other than the individual or department to whom it was addressed.

_____I understand Pirate Pediatrics will not disclose my name, personal information, or e-mail address to anyone without my consent.

_____I understand Pirate Pediatrics cannot accept e-mails from individuals who have not signed this consent form, and all other e-mails will be returned to the sender with a message to this effect.

_____I agree to:

- Include the full name of my child and his/her date of birth in the message.
- Use only the e-mail address below to send messages to Pirate Pediatrics.
- Password-protect my e-mail account and reveal the password only to the people listed below.
- "Sign" the message to show whom the message (i.e., which parent) came from.
- Send only messages without time-urgent issues (such as those mandating a response in less than 24 hours) and without confidential or sensitive issues.
- Send no messages of a non-essential nature, such as jokes, cartoons, chain letters, etc., or any messages, which I know to contain viruses or other damaging files.
- Keep copies (either printed or electronic) of messages I send to and receive from Pirate Pediatrics.
- Respond to messages sent to me by Pirate Pediatrics, either by automatic auto-reply or by a short note.

I have read and understand this consent form and understand the risks and benefits of communicating with Pirate Pediatrics via e-mail. I understand and agree to abide by the policies and procedures for using e-mail to communicate with Pirate Pediatrics. If I fail to comply with this agreement, Pirate Pediatrics has the right to refuse further e-mail messages from me. I consent to my email address being used to access Pirate Pediatrics Patient Portal.

Child(s)/Children(s) name(s): ____
Relationship to patient (circle one)

Mother Father Legal Guardian Other:________________________________

E-mail address to be used: ____
Date Signed: ____

PIRATE PEDIATRICS, PA
FINANCIAL POLICY

ALL PAYMENT IS DUE AT THE TIME OF SERVICE:
Payment is required at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. Co-payments are collected at the time of service. The person bringing your child is responsible for ensuring payment is made. **Please do not involve us in custody/payment issues**. PIRATE PEDIATRICS accepts cash, check (in-state only), and major credit cards. There is a service fee for all returned checks and your account will be placed on a cash only status. If you owe additional fees after your visit, you will receive a statement and payment is expected within 10 days of your statement. Failure to pay outstanding balances will result in collection notices and possible dismissal from PIRATE PEDIATRICS.

INSURANCE:
We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact PedsOne Billing Service between 9:00 a.m. and 5:00 p.m., Monday through Friday at (866) 371-6118.

REFUNDS:
Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will be reviewed on a per claim basis. Upon confirmation and approval of refund, payment will be issued to account holder.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Please arrive 15 minutes prior to your appointment time. If you are late by 15 minutes or more, you will be considered a "no show". Appointments that are cancelled in less than 24 hours or missed appointments may result in a $90.00 fee. Two or more missed appointments may result in discharge from the practice.

FORMS:
Camp forms, sports forms, FMLA forms, special request physician letters, and others at our discretion are completed at a charge of $10 per form/letter completion. Insurance does not cover the cost of form completion. Please allow 5 days for form completion. Additional charges apply for expedited service.

AFTER HOURS:
There is a $20 service fee should you call after hours.

I have read and understand the PIRATE PEDIATRICS Financial Policy. I agree to assign insurance benefits to the PIRATE PEDIATRICS practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured/authorized representative: ______________________________ Date: _______________

PIRATE PEDIATRICS, PA
OFFICE POLICES AND AGREEMENT

Thank you for choosing Pirate Pediatrics as your pediatric medical home. We are committed to providing your child quality health care and excellent customer service. This document was developed to promote a healthy practice-patient relationship. This document will answer many questions you may have about our policies and procedures. Please read each section carefully and initial at the end of each section. By signing, you are acknowledging that you understand each policy and will abide by them. If you have questions please ask any of our staff members.

Appointments
Pirate Pediatrics treats patients from birth to 18 years of age. We will see patients for well child preventative care visits and sick visits. All visits are by appointment only. We encourage you to make your child's follow-up appointment at your visit, as your preferred date and time may not be available. _____

No Shows, Cancellations, and Late Appointments
Please provide 24 hours notice of any appointment cancellations. Failure to do so will result in a No Show. If you are 15 minutes late for your scheduled appointment time you will be considered a No Show and required to reschedule. Appointments that are cancelled in less than 24 hours or missed appointments may result in a $90.00 fee. Two or more missed appointments may result in discharge from the practice. In that case we would provide urgent care for 30 days. _____

After Hours
Our staff is here to assist you from 8:00 AM to 5:00 PM Monday through Friday. If you need medical assistance after hours or on weekends please call 252-364-8790 and a Pirate Pediatrics On Call provider will assist you. There is a $20.00 fee for this service. _____

Insurance
It is your responsibility to provide an **up-to-date copy of your insurance card** at each visit. We understand this may seem repetitive, however it ensures timely filing of your child's visit and potentially reduces your out-of-pocket cost. It is your responsibility to understand your benefit plan. Services not covered by your insurance plan will become your financial responsibility. Some services that may not be covered include developmental screenings, vision and hearing tests, and mental health services. We have contracts with the following insurance companies: Aetna, Blue Cross & Blue Shield, Cigna, Medcost, United Health Care, Tricare, and NC Medicaid. You should verify with your plan if Pirate Pediatrics is in network. _____

Assignment of Benefits
I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Pirate Pediatrics, PA rendered to myself and/or dependents regardless of insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. _____

Financial Responsibility
According to your insurance, you are responsible for any and all co-payments, deductibles, and co-insurance. Co-payments are collected at time of service. The person bringing your child is responsible for ensuring the payment is made. Please do not involve us in custody/payment issues. If you do not have insurance, payment is due on the day of service. Patient refunds will be reviewed on a per claim basis. Upon confirmation and approval of refund, payment will be issued to account holder. _____

Forms
Please allow 5 business days for completion of medical forms. Fees may apply. _____

Vaccines
Pirate Pediatrics values the importance of vaccines and promotes their ability to prevent disease. We follow the CDC schedule for vaccines. **All patients must be vaccinated according to the CDC schedule for vaccines or we will no longer be able to treat your child.** _____

ADHD
Pirate Pediatrics follows American Academy of Pediatrics guidelines for Attention Deficit/Hyper Activity Disorder. At **all** ADHD visits, consults and follow-ups, Vanderbilt forms are required from parents and teachers. **Failure to bring forms from both settings will result in your appointment being cancelled.** Visits are required every 1 to 3 months. _____

Behavior
Pirate Pediatrics prohibits **verbal or physical abuse or threats of any kind** to our providers and staff. This type of behavior will lead to immediate **dismissal from the practice.** Firearms and knives are prohibited on our property. Any item that could be used as a weapon (razor blade, box cutter, etc.) is prohibited. _____

Media
I give Pirate Pediatrics the absolute right and permission to use photographic portraits, pictures, digital images or videos of my child, including but not limited to us in any Pirate Pediatrics publication, social media, or website without payment or any other consideration. _____

By signing below, I agree that I have read the above Policy Agreement. I understand and agree to adhere to the policies included within this agreement.

Patient/Guarantor Name: ____

Patient/Guarantor Signature: ____

Date: ___________________

Acknowledgement of Receipt
Of Notice of Privacy Practices

Pirate Pediatrics, PA
118 Oakmont Drive
Greenville, NC 27858
Phone: (252) 364-8790
Fax: (252) 364-8794

Patient Name: ____
Patient Address: ______________________________________

Pirate Pediatrics' Notice of Privacy Practice is located at piratepediatrics.com.

I have reviewed the document online or a copy has been provided to me for review.

________________________________ ______________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
  - ____
- ☐ Other:____

Prepared By ______________________________________

Signature ______________________________________

Date ______________________________________