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

Welcome aboard 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**
- ☐ **Health History Form:** Provides information about your child's past medical history.
- ☐ **Patient Portal/E-mail Consent Form:** We will attempt to send courtesy appointment reminders and any pertinent forms via the Patient Portal (Ages and Stages Questionnaires, Teacher and Parent Vanderbilts, etc). Please complete the information electronically to prevent rescheduling your appointment.
- ☐ **Financial Policy**
- ☐ **Office Policies and Agreement**
- ☐ **Notice of Privacy Practices**

Please be sure to bring your insurance card(s), driver's license and required co-payment (if any) to the appointment. Payment is due at the time of service.

Also, be sure to visit the website, www.piratepediatrics.com. Our website provides you with valuable information on our policies, scheduling, billing, after hours care and more.

We are also on Facebook as Pirate Pediatrics, PA. Please join us to stay up to date with what is going on at Pirate Pediatrics!

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

PIRATE PEDIATRICS
118 Oakmont Dr. Greenville, NC 27858
Phone number: 252-364-8790
Fax number: 252-364-8794

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____
(First) (Middle) (Last) (mm) (dd) (yyyy)

I authorize _____/_____/_____/_____
(Name of health care entity) (City and State) (Phone Number) (Fax Number)

to release medical information selected below to:

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.

PIRATE PEDIATRICS

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:_____
Email Address: _____

Father/Guardian:_____DOB:____/___/___SSN:_____
Address:_____Cell/Home phone:_____
City/State/Zip:_____Work phone:_____
Email address: _____

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 #:_____

Please submit a copy of your insurance card before your first appointment via our Patient Portal. To submit a copy of your insurance card, login into your Patient Portal and select the Create Message tab. Select message reason as "Other" and click the "Start Message" tab. There you can attach your insurance card to the message.

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 be 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_____

PIRATE PEDIATRICS

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
Weeks at delivery: _____ Birth Weight:_____ Birth Length:_____
Complications during pregnancy: [ ]no [ ]yes; Please explain:_____
Tobacco/alcohol/ drugs during pregnancy: [ ]no [ ]yes ; Please explain:_____

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		
ADHD			Anxiety			Autism		
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)		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	
ADHD		Anxiety		Depression	
Other:		Other:		Other	

IMMUNIZATION HISTORY / NEWBORN SHOTS:

Vaccines save lives. Pirate Pediatrics values the importance of vaccines and promotes their ability to prevent disease. We follow the U.S. Centers for Disease Control and Prevention (CDC) schedule for vaccines. All patients must be compliant with the CDC vaccination schedule (or catch-up schedule). Complete the following and/or please be able to provide a copy of your child's immunization record.

Vaccine	Date(s) Administered
Erythromycin (eye ointment)	
Vitamin K	
Hepatitis B	
DTap	
Polio	
Prevnar (Pneumococcal Conjugate)	
Hib	
Rotavirus	
Hepatitis A	
MMR	
Varicella	
Tdap (Boostrix)	
Menveo (Meningococcal)	
Bexsero (Meningococcal B)	
HPV (Human Papillomavirus)	
Flu	

Form Completed By:_____ **Relationship to Patient:**_____

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

Patient Portal/Email 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

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.

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 payment. Patient refunds will be reviewed on a per claim basis. Upon confirmation and approval of refund, payment will be issued to the account holder. Please do not involve us in custody/payment issues. **A $15 service fee will be charged in addition to your co-pay if your co-pay is not paid at the time of service.** _____

- PIRATE PEDIATRICS accepts cash, check (in-state only), and major credit cards. There is a $35 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 accrual of interest, collection notices and dismissal from PIRATE PEDIATRICS.** _____

INSURANCE:

- **According to your insurance plan, you are responsible for understanding your co-pays, deductibles and coinsurances.** 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. _____

- 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 HealthCare, Tricare, and NC Medicaid – Direct, HealthyBlue or WellCare. You should verify with your plan if Pirate Pediatrics is in network. You will be responsible for all out of network costs. _____

- Pirate Pediatrics is your primary care provider. **Please CONFIRM Pirate Pediatrics** appears on your most up-to-date card. If your insurance has not been informed that Pirate Pediatrics is your primary care provider, you will be responsible for any additional costs. _____

- 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.

PROOF OF INSURANCE:

- All patients must complete our patient information form before seeing a medical provider. We must obtain a copy of your driver's license and your child's current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for payment. _____

SELF PAY:

- If you do not have insurance, payment is due on the day of service. _____

PAYMENT PLANS:

- Broken payment plans will result in interest accrual of charges and a discharge from the practice. Your account will be sent to collections. _____

PIRATE PEDIATRICS, PA
FINANCIAL POLICY

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. _____

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:

- Appointments that are cancelled with less than 24 hour notice or that are missed will result in a fee. The fees are $90 for sick visits, $100 for consultation/specialty and $125 for Well Child visits. _____

FORMS:

- NC Health Assessment and Children Medical Report forms are free of charge. Camp forms, sports forms, FMLA forms, special request physician letters, and others at our discretion are completed at a charge per form/letter completion. There is a $15 fee for all non- NC Health Assessment forms. Forms will be processed within five business days. If you require forms to be expedited, our fees range from $20 to $40 depending on the request. Insurance does not cover the cost of form completion. _____

RECORDS:

- We can release the records directly to you or mail them to another office on a disk drive. If your new health provider request records, we will provide them with a one-time copy, free of charge. If you require records to be printed or uploaded to a disc directly to you, we follow NC Statute 90-411, (maximum fee of $0.75 per page for first 25 pages, $0.50 per page for pages 26-100, $0.25 per page for pages over 100 and a minimum fee of $10). We provide records of your child's visits with Pirate Pediatrics. All records for outside services or providers must be obtained by them directly. _____

AFTER HOURS:

- There is a $30 service fee for after hours calls. There are additional fees for calls that take place outside of 5pm to 10pm and on Holidays. There is a $50 fee for calls between the hours of 10pm and 7am. There is a $60 fee for calls on holidays. There is a $70 fee between the hours of 10pm to 7am on holidays.

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. _____

Printed name of insured/authorized representative: _____ Date: _____

Signature of insured/authorized representative:_____Date: _____

PIRATE PEDIATRICS, PA
OFFICE POLICIES 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. _____

Financial Responsibility:

- I have read, understood and agree to comply with the Financial Policy. _____

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 will be required to reschedule. Appointments that are cancelled in less than 24 hours or missed appointments will result in a fee. Please see our Financial Policy for details. Two or more missed appointments on your account will result in discharge from the practice. _____

After Hours:

- Our staff is here to assist you from 8:00 AM to 5:00 PM Monday through Friday. There are fees associated with after hours calls. Please review our Financial Policy. _____

Communications Consent:

- I consent that the Pirate Pediatrics can provide their services and communicate with me via mobile phone, portal messages, e-mail, voice-mail and any kind of online communications, provided that these communications comply with privacy regulations. _____

Appointment Reminders:

- Pirate Pediatrics attempts appointment reminders as a courtesy to you. Appointment reminders are not guaranteed, and you are responsible for documenting the date and time of your appointment when the appointment is made. I understand that Pirate Pediatrics uses an automated system to reach out me for the purpose to "confirm" or "cancel" my appointment. It is my responsibility to verify I have the correct phone number on file and that I am opted into notifications. _____

Forms:

- Please allow five business days for completion of medical forms. Fees apply as documented in the financial policy. _____

Vaccines:

- Pirate Pediatrics values the importance of vaccines and promotes their ability to prevent disease. We follow the CDC schedule. **All patients must be vaccinated according to the CDC schedule for vaccines to remain a patient at Pirate Pediatrics.** _____

PIRATE PEDIATRICS, PA
OFFICE POLICIES AND AGREEMENT

Preventative Care:

- Preventative Visits or Well Child Visits are required to be an active patient at Pirate Pediatrics. Pirate Pediatrics follows the Bright Futures/American Academy of Pediatrics (AAP) recommendations for Preventive Pediatric Health Care. Failure to follow through with Preventative Care visits will result in your account being discharged from the practice. _____

ADHD:

- Pirate Pediatrics follows American Academy of Pediatrics guidelines for Attention Deficit/Hyper Activity Disorder. **ADHD appointments require up-to-date Well Child Visits per the Bright Futures/AAP schedule**. At **all** ADHD visits, consults and follow-ups, Vanderbilt forms are required from parents and teachers. You **MUST** provide both Teacher and Parent Vanderbilt forms 24 hours prior to your appointment or you will be asked to reschedule and will **NOT** receive medications. Due to the medication side effects used to treat ADHD, rechecks are mandatory every one to three months. See ADHD Medication Policy on PiratePediatrics.com for more details. _____

Behavior:

- Pirate Pediatrics prohibits **verbal or physical abuse or threats of any kind** to our providers and staff. **Harassment and profanity will not be tolerated.** 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 use in any Pirate Pediatrics publication, social media, or website without payment or any other consideration. We will not mention you or your child's name. _____

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 _____