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.
- ☐ **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.

PIRATE PEDIATRICS

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)

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_____

PIRATE PEDIATRICS

NEW PATIENT HEALTH INFORMATION

NAME: _____ **DATE OF BIRTH: ____ /____ /____**

(First) (Middle) (Last) (mm) (dd) (yyyy)

Mother's Name:_____

Father's Name:_____

Sibling(s)/Ages(s):_____

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 that you would like the doctor to know._____

_____

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:	

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

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

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

For Office Use Only:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have reviewed and discussed the "New Patient Health Information" as provided above with the patient/family.

Signature:_____ Date:_____ / _____ / _____

E-Mail 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 who 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 e-mail 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.

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

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment 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 check-in. PIRATE PEDIATRICS accepts cash, check (in-state only), VISA, and MasterCard. 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. 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.

Please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care. The accompanying adult is responsible for payment at the time services are rendered.

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 automatically be refunded to the patient/guarantor.

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.

AFTER HOURS:
There is a $15 service fee should you call after hours and use the Health Direct nurse triage call center.

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 or authorized representative: _____ Date: _____

Notice of Privacy Practices

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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.

Effective Date: December 27, 2011 **Revised: September 22, 2014**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.piratepediatrics.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can receive payment for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be covered. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can

perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Pirate Pediatrics, PA, Attn: Nathan Morgan, 118 Oakmont Dr., Greenville, NC 27858

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 22, 2014.

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: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
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 _____