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

Welcome aboard Pirate Pediatrics! We're thrilled to be your partner in providing top-notch healthcare for your child. From the moment they're born until they reach college age, we're here to support their health and well-being. Thank you for entrusting us with your child's care; it means the world to us. We're excited about the years ahead, where we'll build a lasting relationship and witness your child's journey into a healthy and responsible adult.

To get started on this partnership, we've included our new patient information for you. Kindly complete and submit these documents to our friendly team either before your first visit or at the time of your appointment. We can't wait to meet you and your child and embark on this wonderful adventure of growing up healthy and strong! If you have any questions along the way, feel free to reach out – we're here to help.

- ☐ **Release of Records:** To make sure we provide the best care for your child, we need medical records from any doctors they've seen in the past. For each doctor your child has visited, please take a moment to fill out a separate release form.
- ☐ **Patient Registration Form**
- ☐ **Health History Form**
- ☐ **Patient Portal/E-mail Consent Form:** You'll receive a My Kid's Chart patient portal notification to complete CHADIS documents online before your appointment, saving you time, and avoiding the need to reschedule your appointment. For assistance, use the portal's secure messaging feature.
- ☐ **Financial Policy**
- ☐ **Office Policies and Agreement**
- ☐ **Notice of Privacy Practices**

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.

Make sure to explore our fantastic website at www.piratepediatrics.com – it's packed with valuable resources to support you on your parenting journey. You'll find information about after-hours care, virtual visits, and even ear piercing here at Pirate Pediatrics!

Stay connected with us on social media to be in the loop on what's happening at Pirate Pediatrics.

If you have any questions or need assistance, remember you can always reach out by securely messaging us through the My Kid's Chart patient portal. We're here to help every step of the way!

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 indicate your agreement.

I understand that:

_____Emails can be intercepted and read by unintended recipients.

_____Email is not suitable for urgent, emergent, or sensitive issues.

_____ Emails sent from an employer-provided address may be monitored by my employer.

_____Email messages can be subpoenaed as evidence in legal proceedings.

_____Pirate Pediatrics saves and archives all incoming and outgoing email messages confidentially.

_____Other Pirate Pediatrics staff member may access my email message.

_____Pirate Pediatrics will not disclose my name, personal information, or email address without consent.

_____Pirate Pediatrics cannot accept emails from individuals who have not signed this consent form.

_____I agree to:

- Include my child's full name and date of birth in the message.
- Use only the designated email address below to send messages to Pirate Pediatrics.
- Password-protect my email account and share it only with authorized individuals.
- Identify myself clearly in the message.
- Use email for non-urgent, non-confidential messages and use the portal for non-urgent secure messages.
- Refrain from sending non-essential content such as jokes, cartoons, chain letters, or any messages. containing known viruses or harmful files.
- Maintain copies of sent and received messages.
- Respond to messages sent to me by Pirate Pediatrics as necessary.

I have read and understand this consent form, acknowledging the associated risks and benefits of email communication with Pirate Pediatrics. I agree to adhere to the provided policies and procedures for email communication. Pirate Pediatrics has the right to refuse further email messages from me if I fail to comply with this agreement. I consent to my e-mail address being used for Pediatrics Patient Portal access.

Child(s)/Children(s) name(s): _____

Relationship to patient (circle one)

Mother Father Legal Guardian Other:_____

Email address to be used: _____
Date Signed: _____

PIRATE PEDIATRICS, PA
FINANCIAL POLICY

Please read and initial each section carefully, acknowledging your understanding and agreement to abide by these policies. If you have questions, please ask any of our team members.

ALL PAYMENT IS DUE AT THE TIME OF SERVICE:

- Payment is required at the time services are rendered, including applicable coinsurance and copayments for participating insurance. Copayments are collected up front. The individual accompanying your child is responsible for payment. Patient refunds will be reviewed on a per claim basis, and approved refunds will be issued to the account holder. Please refrain from involving us in custody/payment issues. **A $20 service fee is added if co-pay is not paid at the time of service.** _____

- PIRATE PEDIATRICS accepts cash, in-state checks, and major credit cards. A $40 service fee applies to returned checks, resulting in a cash-only account status. Any additional fees post-visit must be settled within 10 days of the statement. _____

- Balances must be settled before appointments are scheduled. **Failure to clear outstanding balances will lead to interest accrual, collection notices and dismissal from PIRATE PEDIATRICS.** _____

INSURANCE:

- **Familiarize yourself with your insurance plan's copays, deductibles, and coinsurances.** We bill participating insurance companies as a courtesy to you. Deductibles and copayments are expected at the time of service. If payment from your insurance has not been received within 45 days of service, you are responsible for the full balance. You must ensure all charges are settled, whether by you or by your insurance. Your time-of-service receipt includes all required information necessary for submitting claims. _____

- Services not covered by your insurance become your financial responsibility. Examples may 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. Confirm with your plan whether Pirate Pediatrics is in-network; out-of-network costs are your responsibility and are due at the time of service. ____

- **Verify that Pirate Pediatrics is designated as your primary care provider on your most recent insurance card.** If your insurer is unaware of Pirate Pediatrics as your primary care provider, you assume 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:

- Complete our patient information form before seeing a medical provider. Providing a copy of your driver's license and your child's current valid insurance card is required for verifying insurance. Failure to provide accurate insurance information will result in your financial responsibility. _____

CREDIT CARD ON FILE (CCOF)

- All patients, regardless of insurance, must maintain a valid Credit Card on File (CCOF) to expedite processing of outstanding balances or copayments. _____

SELF-PAY PATIENTS:

- If you lack insurance, payment in full is required on the day of service. Self-pay patients must also maintain an active CCOF. ____

PAYMENT PLANS:

- All payment plans require an active CCOF. Failure to adhere to payment plans leads to interest accrual, collection, and discharge from the practice. _____

PIRATE PEDIATRICS, PA
FINANCIAL POLICY

ASSIGNMENT OF BENEFITS:

- I assign all entitled medical and surgical benefits, including major medical benefits, to Pirate Pediatrics, PA. I authorize and direct my insurance carrier(s) to issue payment directly to Pirate Pediatrics, PA, for services rendered to myself and/or dependents regardless of insurance benefits. I acknowledge responsibility for any uncovered amounts. _____

REFUNDS:

- Patient/guarantor credits less than $20.00 are retained on account for future balances unless a written refund request is received. Amounts exceeding $20.00 are reviewed on a per claim basis, and approved funds are issued to the account holder._____

MISSED APPOINTMENTS/LATE CANCELLATIONS:

- Any missed appointments, which includes arriving late or canceling with less than 24-business-hour notice, will incur a fee. The fee amounts are as follows: $90 for sick visits, $100 for consultation/specialty appointments, and $125 for Preventative Care Well Child visits. Appointments cannot be scheduled until the missed appointment fee has been paid. For further information, please refer to the Missed Appointments section in our Office Policies. _____

FORMS:

- Completion of NC Health Assessment and Children Medical Report forms is provided free of charge. Other forms, e.g., camp forms, sports forms, FMLA forms, special request physician letters, and others are completed at a charge per form/letter. A $15 fee applies to non-NC Health Assessment forms. Standard processing takes five business day; expedited processing fees range from $20 to $40 depending on the request. Insurance does not cover the cost of form completion. _____

RECORDS:

- We release records directly to you or mail them to another office on a disk drive. New healthcare providers receive a one-time copy, free of charge. Printed or uploaded records to you incur fees following NC Statute 90-411, ranging from $0.75 per page for first 25 pages, $0.50 per page for pages 26-100, $0.25 per page for pages over 100, with a minimum fee of $10. We provide records of your child's visits with Pirate Pediatrics only. Records for outside services or providers must be obtained directly from them. _____

AFTER HOURS:

- Virtual after-hours visits are billed to your insurance, with potential copays and deductibles. Consult your insurance policy for coverage details.
- A $30 service fee applies to after-hours phone call advice. Additional fees vary: $50 for calls from 10pm to 7am, and $60 for calls on holidays. Calls between 10pm to 7am on holidays incur a $70 fee.

I have read and understand the PIRATE PEDIATRICS Financial Policy. I agree to assign insurance benefits to the PIRATE PEDIATRICS practice whenever necessary. If my account requires collection agency assistance, I acknowledge responsibility for both the outstanding amount and any associated collection fees. _____

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

Signature of insured/authorized representative:_____Date: _____

Credit Card on File (CCOF)

To streamline payments and collections, we require a securely stored credit card on file (CCOF).

Please note your credit card information will be kept off-site, and we won't store credit card numbers at our practice. If you have insurance, copayments are due at the time of your visit. Your Explanation of Benefits (EOB) will detail your insurance coverage, and you'll receive a statement for any remaining balance. Unpaid balances after 30 days will be charged to the credit card on file.

For inquiries regarding this payment method, please contact our Billing Office at 866-371-6118. If you don't have insurance, full payment is required on the day of your visit.

What advantages does having a credit card on file offer me?

With our credit card on file, (CCOF) system you will be able to:

- Easily cover your insurance obligations like copays, coinsurance, deductibles, non-covered services
- Save both time and money by eliminating the need for check-writing and mailing bills.
- Receive advance notifications before any CCOF charges are applied
- Enjoy a fully virtual and touchless payment process
- Prevent extra charges, including service fees for copay non-payment at the time of service, fees for returned checks, interest charges, and collection fees

Your credit card on file can be used for the following:

- Payments at the time of your visit, including copays and other expenses
- Deductibles and services not included in your insurance coverage
- Fees related to missed appointments, late cancellations or after hours services
- Additional expenses such as overdue balances, interest fees, service charges for returned checks

The **Credit Card Authorization Agreement** will be effective for all family members on your account. Once we've securely stored your credit card information in our offsite encrypted system, the full details will be destroyed, and we'll retain only the last 4 digits. You can also provide your credit card information over the phone or in person for added convenience.

_____ _____

Patient(s) Printed Name Parent/Guardian Signature

_____ _____

Parent/Guardian Printed Name Date

Understanding Credit Card on File (CCOF)

- **What is a deductible and how does it affect me?**
  - Each year, your insurance policy may require a deductible that must be paid toward medical expenses before your policy begins to pay for your visits. For example, if your policy has a deductible of $5,000, you will be responsible for paying the first $5,000. Note that Preventative Care Visits (Well Child Visits) are not included in the deductible.

- **When do I have to pay for services?**
  - Patients are responsible for all charges any time you receive services from us. You are expected to pay in full for your services until your deductible and any applicable co-insurance are met. You can contact your insurance company at any time to check how much of your deductible has been met.
  - After each service, your insurance will send you an Explanation of Benefits (EOB), indicating how much they have paid and how much is patient responsibility. "Patient responsibility" means the amount your insurance requires you to pay for the services you received. Pirate Pediatrics reviews this EOB and collects patient responsibility.

- **What about identity theft and privacy?**
  - We strictly adhere to HIPAA regulations to protect patient privacy. Credit card information is classified as protected health information and is encrypted and securely stored off-site, never retained at our practice.

- **What if I don't have a credit card?**
  - We provide various payment options, including leaving a Health Savings Account card (HSA) or Debit card on file, accepting cash or valid checks. Payment is due at the time of service and/or upon receipt of your billing statement. Unpaid accounts will receive subsequent statements, but if your balance remains 90 days overdue, we will involve a collection agency and terminate our professional relationship.

- **When will my card be charged?**
  - You can request a charge to your CCOF at any time. If we have your health insurance on record, we will send the claim for processing as a courtesy to you. You will receive a billing statement, with 30 days to pay any patient responsibility. If the balance is not received by day 31, the balance is charged to your CCOF. You can update your CCOF anytime.

- **How will I know you have charged my credit card?**
  - You will receive a receipt in your patient portal after the charge is made.

- **What charges will my card be used for?**
  - Your credit card can cover time-of-service payments, missed appointment or late cancellation fees, returned check fees service fees, after hours service fees, interest, past-due balances, and any responsibility determined by your insurance.

- **What if my card is declined or expired?**
  - It is your responsibility to keep your card on file updated. We will contact you **once** to update your credit card information. Delinquent accounts will be sent to collections, leading to the termination of our professional relationship.

- **What if I want to change the credit card on file?**
  - You can provide your new credit card by calling or visiting our office or securely through the patient portal by submitting photos of the front and back of the card.

- **What if there is an error in my bill?**
  - Please contact our billing off at 866-371-6118.

- **When do I give you my credit card?**
  - You'll provide your credit card details upon completing the Credit Card Authorization Agreement, which covers your entire family. After entering your information into our encrypted system, it will be **destroyed**. You can also provide verbal consent or securely send a photo of the front and back of your card via the patient portal.

- **What if I have more questions?**
  - We are happy to help with your account inquiries; feel free to call our Billing Office at 866-371-6118.

Credit Card Authorization Agreement

I, _____, hereby authorize Pirate Pediatrics to use my credit card for healthcare-related charges. This includes copays, service fees, missed appointment or late cancellation fees, after hours service charges, account balances, interest, non-covered services, and other associated fees.

I understand my credit card details will be securely stored and that all transactions will follow Pirate Pediatrics' policy. I am responsible for maintaining accurate credit card information.

By signing this authorization, I agree to the terms and authorize Pirate Pediatrics to charge my credit card for any owed service amounts.

Credit Card number: _____

Expiration Date: _____ / _____ Security Code: _____

Name on the Card: _____

Signature of Authorized User: _____

Date: _____

Children: _____
_____
_____
_____

Pirate Pediatrics
252-364-8790

PedsOne Billing
866-371-6118

PIRATE PEDIATRICS, PA
OFFICE POLICIES AND AGREEMENT

Thank you for choosing Pirate Pediatrics for your child's health. We are dedicated to delivering quality health care and excellent customer service. This document outlines our policies and procedures to establish a healthy practice-patient relationship. Please read and initial each section carefully, acknowledging your understanding and agreement to abide by these policies. If you have questions, please ask any of our team members.

Appointments:

- Pirate Pediatrics welcomes patients from infancy to college age, providing services such as well-child preventative care, behavioral/mental health visits, virtual appointments, and both acute and chronic care visits. We offer a designated walk-in period, while all other appointments are by appointment only. To secure your preferred date and time, we recommend scheduling follow-up appointments during your visit. _____

Financial Responsibility:

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

Missed Appointments, Cancellations, and Late Arrivals:

- Not attending a scheduled appointment or failing to provide a 24-business-hour cancellation notice is considered a missed appointment. Arriving more than 15 minutes late for your appointment also counts as a missed appointment, requiring rescheduling. Please be aware all missed appointments, including late arrivals, result in a fee as specified in our Financial Policy. Two or more missed appointments on your account will lead to discharge from the practice. _____

After Hours:

- Our staff is here to assist you from 8:00 AM to 5:00 PM Monday through Friday. After-hours calls are subject to associated fees outlined in our Financial Policy. _____

Communications Consent:

- I consent to Pirate Pediatrics providing services and communicating with me through various methods, including mobile phone, portal messages, e-mail, voicemail and online communications, ensuring compliance with privacy regulations. _____

Appointment Reminders:

- Pirate Pediatrics offers appointment reminders as a courtesy. These reminders are not guaranteed, so it is essential to note your appointment date and time when scheduling. We use an automated system to confirm appointments, so please verify we have your correct phone number, and that you are opted into notifications. _____

Forms:

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

Vaccines:

- Pirate Pediatrics prioritizes vaccinations to prevent disease, following the CDC schedule. **To remain our patient, all patients must be vaccinated according to this schedule.** _____

PIRATE PEDIATRICS, PA
OFFICE POLICIES AND AGREEMENT

Preventative Care:

- To maintain active patient status at Pirate Pediatrics, it is necessary to attend Preventative Care Well Child Visits, following Bright Futures/American Academy of Pediatrics (AAP) recommendations is essential. Non-compliance with these visits will lead to discharge from the practice. _____
- Non-preventative services are not covered during well child visits by your insurance. Some examples include ADHD, asthma, anxiety, rash, ear pain, knee pain, bedwetting, constipation. Deductibles, copays, and coinsurance apply. __

ADHD:

- Pirate Pediatrics follows American Academy of Pediatrics guidelines for Attention Deficit/Hyperactivity Disorder (ADHD). **ADHD appointments require up-to-date Preventative Care Well Child Visits as per the Bright Futures/AAP schedule**. For **all** ADHD consultations and follow-ups, both Parent and Teacher Vanderbilt forms are mandatory and must be provided 24 hours prior to your appointment. Without both forms, you will be asked to reschedule and will **NOT** receive medications. Due to the potential medication side effects, rechecks are required every one to three months. See ADHD Medication Policy on PiratePediatrics.com for more details. _____

Behavior:

- Pirate Pediatrics strictly prohibits **verbal or physical abuse, threats, harassment, and profanity** towards our providers and staff, including damage to our property. Such behavior will result in **immediate dismissal from the practice.** Firearms and knives are prohibited on our property, and the use of any item that could weaponized (razor blade, box cutter, etc.) is strictly forbidden. _____

Media:

- I grant Pirate Pediatrics the unconditional right and permission to use photographic portraits, pictures, digital images or videos of my child, including but not limited to their use in any Pirate Pediatrics publications, social media, or website, without payment or consideration. No personal names will be mentioned. _____

By signing below, I confirm that I have read and understood the Policy Agreement above. I agree to adhere to the policies outline in 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 can be found on our website at piratepediatrics.com.

I have either reviewed the document online or I have received a copy for my 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 _____