



GROW Pediatrics & Adolescent Medicine, PLLC

1600 W 38TH ST STE105

AUSTIN TX 78731

P: 512-467-7334 | F: 512-467-7335

growpediatrics.com

Today's Date	PCP:
--------------	------

How did you hear about us?

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Nickname:	Date of Birth:	Gender:
Street Address:	City, State & Zip Code	

Lives with:

GUARANTOR (PARENT HOLDING INSURANCE)

Please give your insurance card to the receptionist.

Guarantor's Last Name:	First:	Middle:	
Relationship to Patient:	Date of Birth:		
Address (if different)			
Home Phone:	Mobile Phone:	Email Address:	
Insurer:	Policy/Member ID:	Group no:	Co-pay:

OTHER PARENT (NOT HOLDING INSURANCE)

Parent's Last Name:	First:	Middle:
Relationship to Patient:	Date of Birth:	
Address (if different)		
Home Phone:	Mobile Phone:	Email Address:

SIBLINGS AT THIS PRACTICE

Name:	Date of Birth:	Gender:
Name:	Date of Birth:	Gender:
Name:	Date of Birth:	Gender:

PHARMACY INFORMATION

Preferred Pharmacy:	Phone:
Address/Cross Streets:	

IN CASE OF EMERGENCY

The following people are authorized to bring my child for any necessary treatment and may sign informed consent forms in my absence:

Name:	Relationship to patient:	Phone:
1.		
2.		
3.		

Other important information:

**GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
NEWBORN INSURANCE WAIVER**

I, _____, have not provided GROW Pediatrics & Adolescent Medicine, PLLC with my child, _____'s completed insurance information (completed insurance information means the child has been enrolled and confirmed as active on the health insurance policy GROW Pediatrics has on file).

I acknowledge coverage is not effective until I have provided GROW Pediatrics & Adolescent Medicine, PLLC with the necessary insurance information for my child, and I understand all balances must be paid in full within thirty (30) days. Further, I understand my signature below denotes me as financially responsible for all patient balances. This waiver states, therein, the signer accepts full responsibility for any and all unpaid charges after a period of thirty (30) days has elapsed.

Parent/Legal Guardian Signature _____ Date _____

**GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
CONSENT TO TREATMENT OF A MINOR**

In my absence, I authorize GROW Pediatrics and Adolescent Medicine, PLLC and staff to evaluate and treat _____, a minor child, that in his or her judgment, the physician determines advisable for the child's well-being.

Note: If any special parental or custodial relationship exists (such as if the child has one parent only, or if legal custody is held by guardians in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Parent or Guardian Name _____

Relationship to Patient _____

Parent or Guardian Signature _____

Date _____

Witness Signature _____

Date _____

*Witness Signature _____

Date _____

** If parent or guardian is giving verbal authorization over the telephone, a second witness should be documented.*

**GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
AND REQUESTED RESTRICTIONS**

By signing below, you acknowledge that the *Notice of Privacy Practices* was made available to you for review prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your/your child's medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my/my child's information:

Patient Name: _____ Patient Date of Birth: _____

Parent/Legal Representative/Patient: _____ Date: _____

If Legal Representative, relationship to Patient: _____

GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
PATIENT FINANCIAL POLICY

In compliance with the Federal Consumer Protection Act, GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC wishes to notify you of our policies regarding the financial responsibilities associated with services rendered to your child.

Insurance

Co-payments are due and payable at the time of service. As a courtesy, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct and active insurance details, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Self-Pay Account

If proof of insurance is not provided, your account will be considered a self-pay account and payment in full of all charges will be required at the time of service. If you subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will bill the charges to your insurance company for you. If we then receive insurance payment, we will promptly issue a refund to you of any credit on your account.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments, adjustments, and pending amounts. Patient balances are due from you upon receipt of the statement.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a \$50 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive more than 10 minutes late.

After Hours Phone Calls

Our office hours are Monday-Friday 8:00am-5:00pm. To page the on-call provider outside these hours, please call MedLink at 512-660-6581. There is a \$25 charge for this service.

After Hours Visits

We will bill your insurance company for an after-hours fee for acute care (non-preventative) appointments held after hours. Your insurance company may not cover this fee. In the case it is not covered, you will be responsible for the after-hours fee (which is generally \$30-40).

Returned Checks

There is a \$25 returned check fee in the event a personal check is returned to us for any reason.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

I authorize the release of any medical or other information necessary to process my child's insurance claim. I authorize payment of medical benefits to GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC for services rendered and agree to abide to the above noted financial policy.

Parent/Guardian Signature

Date

NEW PATIENT



QUESTIONNAIRE

PATIENT LAST NAME: _____ FORM COMPLETED BY: _____

PATIENT FIRST NAME: _____ RELATION TO PATIENT: _____

DATE OF BIRTH: ____/____/____ DATE OF FIRST APPOINTMENT: ____/____/____

MEDICAL HISTORY

Does your child have any serious illnesses or medical conditions?

No medical conditions

Date of Diagnosis (mth/yr)	Condition

Has your child undergone any surgery?

No history of surgery

Date (mth/yr)	Surgical Procedure

Has your child ever been hospitalized?

No hospitalizations

Date (mth/yr)	Reason for Admission

Does your child see any medical specialists?

No specialists

Specialty	Provider's Name

Does your child have any allergies or adverse reactions to food, drugs, etc.?

No known allergies

Allergy	Reaction

Does your child currently take any medications or vitamins?

No current medications

Name	Dosage	Frequency

DEVELOPMENTAL

Birth weight ____lbs ____oz

Gestational Age _____wks

Any complications? _____

NICU stay? No Yes;

Reason _____

Delivery? Vaginal Cesarean

Initial Feeding? Formula Breast milk;

How long breastfed? _____

Circumcision? No or N/A Yes:

Date ____/____/____

At what age did your child learn to:

Walk? _____ Talk? _____

Has your child ever engaged with rehabilitative therapies? No

PT In the past Currently

Reason _____

OT In the past Currently

Reason _____

ST In the past Currently

Reason _____

For girls:

Has had first period? No Yes;

Age of first period _____

Any problems with her periods?

FORM CONTINUES ON BACK!

HOUSEHOLD

Parent 1 Name: _____

Parent 2 Name: _____

Occupation: _____

Occupation: _____

Allergies: _____

Allergies: _____

Height (in): _____

Height (in): _____

Glasses/Contacts? No Yes

Glasses/Contacts? No Yes

Siblings? No

Check if your child attends...

Daycare?

Name of Daycare

School?

Name of School *Grade Level*

Living Situation (check all that apply):

Married Separated Divorced

Lives with both parents Adopted

Lives primarily with P1 / P2 (*circle one*)

Lives with appointed guardian:

Is there a pool at home?

No Yes

Are there any firearms at home?

No Yes

Is there any tobacco use/second hand smoke exposure in the home?

No Yes

Is there any substance abuse (drugs/alcohol) in the family?

No Yes

Name	Age

FAMILY HISTORY

Please list family members (from the patient's frame of reference) in the space next to listed conditions if they have had any of the following:

CARDIO <i>(especially if before age 55)</i>	Arrhythmia	
	Heart attack	
	Heart murmur	
	High cholesterol	
	High blood pressure	
	Stroke or TIA	
NEURO	Seizures or epilepsy	
	Migraines	
	ADHD/ADD	
	Dementia or Alzheimer's	
	Sleep disorder	
MENTAL HEALTH	Depression	
	Anxiety	
	Bipolar Disorder	
DERM	Eczema	
	Acne	
PULM	Asthma	
CANCER	(type)	
	(type)	
	(type)	

ABBREVIATIONS:

M (Mother)

F (Father)

B (Brother)

S (Sister)

PGM (Paternal Grandmother)

PGGF (Paternal Great Grandfather)

MGF (Maternal Grandfather)

MGGM (Maternal Great Grandmother)

MA (Maternal Aunt)

PU (Paternal Uncle)

MC (Maternal Cousin)

GENETIC	Cystic fibrosis	
	Huntington's Disease	
	Fragile X	
	Muscular dystrophy	
ENDOCRINE	Diabetes mellitus	
	Thyroid disease	
	Growth disorder	
GI	GERD	
	IBS	
	Celiac Disease	
BLOOD	Anemia	
	Bleeding/clotting disorder	
OTHER	Auto-immune disease	
	Hearing or vision problems	
	Developmental delay	
	Autism Spectrum Disorder	

Additional family history _____