GROW Pediatrics & Adolescent Medicine, PLLC
1600 W 38TH ST STE 105
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 INISURANCE)

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
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 no 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

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growpediatrics.com

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

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

INFORMATION TO BE RELEASED FROM:

____ GROW Pediatrics

____ Other:

Organization/Person:

Address:	
Phone:	Fax:

INFORMATION TO BE RELEASED TO:

____ GROW Pediatrics

____ Other:

Organization/Person:

Address:	
Phone:	Fax:

PURPOSE OF RELEASE

____ Legal ____ Personal Use ____ Continuing Care ____ Transfer to Another Provider ____ School ____ Other:

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization by any time by written notification to GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: _____

Sensitive Records may require specific patient authorization. Please indicate which sensitive records you authorize us to release:
____ Drug/Alcohol abuse/treatment/diagnosis ____ Sexually transmitted diseases ____ Mental Health Treatment ____ HIV/AIDS diagnosis/treatment/testing

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care, such as birth control, pregnancy-related services, and sexually transmitted diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

Signature of Minor Patient Date

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative Date

Printed Name of Parent/Legal Representative Relationship to Patient

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: _____

Occupation: _____

Allergies: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

Parent 2 Name: _____

Occupation: _____

Allergies: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

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:

_____

Siblings? ☐ No

Name	*Age*

Check if your child attends…

☐ Daycare?

_____

Name of Daycare

☐ School?

_____ _____

Name of School *Grade Level*

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

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:

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)

CARDIO *(especially if before age 55)*	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)	

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 _____

_____