



Welcome to the GROW family!

New Patient Paperwork Checklist:

- ☐ New Patient Demographics
- ☐ New Patient Questionnaire
  - ☐ PART 1: PATIENT
  - ☐ PART 2: FAMILY
- ☐ Consent to Treatment of a Minor
- ☐ Financial Policies
- ☐ Office Policies
- ☐ Records Request
- ☐ ImmTrac2 Registry (*OPTIONAL*)

Completed Paperwork:

Please email completed paperwork to [info@growpediatrics.com](mailto:info@growpediatrics.com) in a **PDF** format.

No photos please!

Don't have a scanner? There are several scanner apps available for your phone.

- CamScanner
- Microsoft Office Lens
- Turbo Scan
- Evernote Scannable
- Scanbot
- Tiny Scanner



GROW Pediatrics & Adolescent Medicine, PLLC  
1600 W 38<sup>TH</sup> ST., STE. 105  
AUSTIN, TX 78731  
P: 512-467-7334 | F: 512-467-7335  
growpediatrics.com

## NEW PATIENT DEMOGRAPHICS

|               |      |
|---------------|------|
| 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: |         |

### GUARANTOR (PARENT HOLDING INSURANCE)

Please give your insurance card to the receptionist at appointment.

|                          |                   |           |         |
|--------------------------|-------------------|-----------|---------|
| Guarantor's Last Name:   | First:            | Middle:   |         |
| Relationship to Patient: | Date of Birth:    |           |         |
| Address (if different)   |                   |           |         |
| Phone Number:            | 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)   |                |         |
| Phone Number:            | Email Address: |         |

### PHARMACY INFORMATION

|                        |        |
|------------------------|--------|
| Preferred Pharmacy:    | Phone: |
| Address/Cross Streets: |        |

### CONTACT OPTIONS

Please mark your preference with an **X** or **✓**

Which phone number would you like to be assigned as primary contact to receive the text/call reminders from our office?

\_\_\_ Guarantor's Phone Number    \_\_\_ Other Parent's Phone Number    \_\_\_ Other Phone Number: \_\_\_ - \_\_\_ - \_\_\_

#### Authorization for Voicemail Usage for PHI:

I hereby give permission to leave a message on the voicemail or answering machine concerning my child's personal health information.

Please initial if declining: \_\_\_\_\_

Which email address would you like to be assigned as primary contact to receive access to patient portal?

\_\_\_ Guarantor's Email    \_\_\_ Other Parent's Email    \_\_\_ Other Email: \_\_\_\_\_

## NEW PATIENT



## QUESTIONNAIRE

PART 1:  
PATIENT

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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 ☐ CesareanInitial 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? ☐ NoPT ☐ In the past ☐ Currently

Reason \_\_\_\_\_

OT ☐ In the past ☐ Currently

Reason \_\_\_\_\_

ST ☐ In the past ☐ Currently

Reason \_\_\_\_\_

Check if your child attends...

☐ Daycare?\_\_\_\_\_  
Name of Daycare☐ School?\_\_\_\_\_  
Name of School

For girls:

Has had first period? ☐ No ☐ Yes;

Age of first period \_\_\_\_\_

Any problems with her periods?

\_\_\_\_\_

Grade  
Level

## NEW PATIENT



## QUESTIONNAIRE

PART 2:  
FAMILY

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HOUSEHOLD

Parent 1 Name: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Height (in): \_\_\_\_\_

Height (in): \_\_\_\_\_

Glasses/Contacts? ☐ No ☐ YesGlasses/Contacts? ☐ No ☐ YesMarital Status:

- ☐ Married ☐ Single
- ☐ Divorced ☐ Separated
- ☐ Other: \_\_\_\_\_

Living Situation:

- ☐ Lives with both parents
- ☐ 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 ☐ Yes, locked

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

From the patient's frame of reference, mark family members in the grid next to listed conditions if they have had any of the following:

|                                         |                                   | Mother | Father | Sibling | Grandmother | Grandfather | Aunt/Uncle | Cousin |
|-----------------------------------------|-----------------------------------|--------|--------|---------|-------------|-------------|------------|--------|
| CARDIO<br>(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/Learning disorder        |        |        |         |             |             |            |        |
|                                         | Dementia or Alzheimer's           |        |        |         |             |             |            |        |
| MENTAL HEALTH                           | Depression/Anxiety                |        |        |         |             |             |            |        |
|                                         | Bipolar Disorder                  |        |        |         |             |             |            |        |
| DERM                                    | Eczema                            |        |        |         |             |             |            |        |
|                                         | Acne                              |        |        |         |             |             |            |        |
| PULM                                    | Asthma                            |        |        |         |             |             |            |        |
| CANCER                                  | (elaborate type/individual below) |        |        |         |             |             |            |        |

|           |                            | Mother | Father | Sibling | Grandmother | Grandfather | Aunt/Uncle | 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 \_\_\_\_\_

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## CONSENT TO TREATMENT OF A MINOR

### APPLICABLE PATIENT(S)

| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|
|           |            |               |
|           |            |               |
|           |            |               |
|           |            |               |

### GENERAL CONSENT

  
INITIAL  
REQUIRED

I authorize GROW Pediatrics and Adolescent Medicine, PLLC and staff to provide reasonable and necessary medical examination, testing, and treatment to my child(ren) that the physician determines advisable for the child(ren)'s well-being.

This authorization has no expiration, and any changes must be made in writing.

### TO PERMIT SPECIFIED INDIVIDUALS TO ACCOMPANY CHILD(REN)

  
INITIAL  
OPTIONAL

In my absence, I authorize the following individuals to accompany my child(ren) to GROW Pediatrics for the provision of medical services and to view and discuss my child(ren)'s Protected Health Information (PHI).

| First and Last Name | Phone Number | Date of Birth | Relationship to Patient | Emergency Contact (✓) |
|---------------------|--------------|---------------|-------------------------|-----------------------|
|                     |              |               |                         |                       |
|                     |              |               |                         |                       |
|                     |              |               |                         |                       |
|                     |              |               |                         |                       |

### TO PERMIT ONLY PARENT/GUARDIAN TO ACCOMPANY CHILD(REN)

  
INITIAL  
OPTIONAL

I DO NOT authorize anyone other than the child(ren)'s father, mother, and/or guardian to accompany my child(ren) to GROW Pediatrics for the provision of medical services.

Please list any explicit limitations/restrictions below:

### CONSENT TO TREAT UNACCOMPANIED MINOR (16 years and older)

  
INITIAL  
OPTIONAL

I request and authorize GROW Pediatrics and its staff to provide medical care to my minor child(ren) over the age of 16 years when unaccompanied for routine, preventative, and/or sick visits.

I understand I must have a valid phone number on file in my child(ren)'s chart for verification purposes.

*NOTE: Per GROW Pediatrics policy, certain immunizations require the patient to stay in our waiting room 15 minutes POST administration. For their safety, please allow for this time in your child(ren)'s schedule.*

### SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative

Date

Printed Name of Parent/Legal Representative

Relationship to Patient



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## FINANCIAL POLICIES

### INSURANCE

  
INITIAL

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, all charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient or not covered by your insurance plan. 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 ACCOUNTS

  
INITIAL

If proof of insurance is not provided, your account will be considered a self-pay account. Payments in full at time of service may be eligible for a discount. If you subsequently provide verifiable insurance information, and the timeframe for billing the insurance has not expired, 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/PAYMENT OPTIONS

  
INITIAL

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

We accept all major debit/credit cards, FSA/HSA cards, checks, and cash. Payment can be made by returning the statement by mail, calling our office, or online through the Patient Portal.

### DELINQUENT ACCOUNTS

  
INITIAL

GROW Pediatrics makes every attempt to notify you of any balances. Outstanding balances not paid within 30 days will be considered delinquent. After 90 days your account will be reviewed for submission to a collection agency.

If you are not able to remit full payment, please contact our Billing Specialist to make payment arrangements. Depending on the amount of the balance, payment plans for no more than a 6 month time frame may be granted on an individual basis.

### AFTER-HOURS

  
INITIAL

#### 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.

#### VISITS

We will bill your insurance company for an after-hours fee for acute care (non-preventative) appointments. Since we do not regularly hold weekend hours, this service may not be covered and you will be responsible for the after hours fee.

### FEES

  
INITIAL

|                           | <u>Policy</u>                                                                              | <u>Amount</u>         |
|---------------------------|--------------------------------------------------------------------------------------------|-----------------------|
| Returned Checks           | In the event a personal check is returned to us for any reason.                            | \$25                  |
| No-Show/Late Cancellation | If your appointment is missed or cancelled with less than 24 hour notice                   | \$50                  |
| Forms                     | For the completion of forms outside an office visit for school, camp, sport, daycare, etc. | \$10 / Expedited \$25 |

### ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

  
INITIAL

- I authorize payment of medical benefits to GROW Pediatrics and Adolescent Medicine, PLLC for services rendered and understand that I will be fully responsible for any outstanding balance.
- I authorize the release of any medical or other information necessary to process my child's insurance claim.
- I authorize GROW Pediatrics to initiate a complaint or file appeal to my insurance company or any payer authority for any reason on my behalf.

### SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative

Date

Printed Name of Parent/Legal Representative

Relationship to Patient



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## OFFICE POLICIES

### APPLICABLE PATIENT(S)

| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|
|           |            |               |
|           |            |               |
|           |            |               |
|           |            |               |

### PRIVACY PRACTICES AND REQUESTED RESTRICTIONS

INITIAL

I acknowledge that the Notice of Privacy Practices was made available to me for review prior to any service being provided by the Practice, and I consent to the use and disclosure of my child(ren)'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 child(ren)'s information:

### VACCINE POLICY

INITIAL

I acknowledge that I received, reviewed, and agree to comply with the GROW Pediatrics Vaccine Policy.

### APPOINTMENTS-LATE/CANCELLATION

INITIAL

If a patient has not arrived within 10 minutes of their scheduled appointment, our office will call the phone number on file. If the patient arrives more than 15 minutes after the appointment time, we will need to reschedule the appointment.

If you need to cancel an appointment, we ask parents to call us at least 24 hours ahead of a scheduled well visit or four hours prior to a 'sick' appointment. While we understand that unforeseen problems occur, we reserve the right to charge a fee of \$50 when these guidelines are not followed.

### SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative

Date

Printed Name of Parent/Legal Representative

Relationship to Patient



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## 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 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 pertaining to the diagnosis and treatment of specifically protected or privileged categories require patient authorization. Please INITIAL which records you authorize us to release:

☐ Drug/Alcohol abuse ☐ Sexually transmitted diseases ☐ Mental Health ☐ HIV/AIDS testing ☐ Other:

### SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information related to: 1) 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

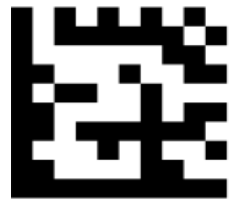
A complete records request takes our office up to 14 business days to process. A record of more than 40 pages cannot be faxed and will be copied to a disc for mailing. As a courtesy, GROW Pediatrics fulfills one complete records request per patient at no charge with a \$25 fee for any additional requests.



Texas Department of State  
Health Services

# IMMUNIZATION REGISTRY (ImmTrac2)

## Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

\*Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Date of Birth

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

**The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.**

### Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • [www.ImmTrac.com](http://www.ImmTrac.com)

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

**PROVIDERS REGISTERED WITH ImmTrac2:** Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT** fax to ImmTrac2. **Retain this form in your client's record.**