GROW Pediatrics & Adolescent Medicine, PLLC
1600 W 38TH 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: _____

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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 ACCOMANY 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 ACCOMANY CHILD(REN)

INITIAL
OPTIONAL

I DO NOT authorize anyone other that 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 an 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

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 ☐ 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_____

Check if your child attends...

☐ Daycare?

_____

Name of Daycare

☐ School?

_____ _____

Name of School *Grade Level*

For girls:

Has had first period? ☐ No ☐ Yes;

Age of first period_____

Any problems with her periods?

_____

APPLICABLE PATIENT(S)

Last Name	First Name	Date of Birth

HOUSEHOLD

Parent 1 Name: _____

Occupation: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

Marital Status:

☐ Married ☐ Single

☐ Divorced ☐ Separated

☐ Other:

_____

Parent 2 Name: _____

Occupation: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

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 (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							

_____

_____

_____

_____

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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

	Policy	Amount
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