GROW Pediatrics & Adolescent Medicine, PLLC
1401 Philomena St., Ste 120
Austin, TX 78723
P: 512-467-7334 I F: 512-467-7335
growpediatrics.com

NEW FAMILY DEMOGRAPHICS

Today's Date:	PCP:
How did you hear about us?	

PATIENTS' INFORMATION

Patient's Last Name:	First:	Middle:
Nickname:	Date of Birth:	Gender:
Patient's Last Name:	First:	Middle:
Nickname:	Date of Birth:	Gender:
Patient's Last Name:	First:	Middle:
Nickname:	Date of Birth:	Gender:
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 <u>phone number</u> would you like to be assigned as primary contact to receive the <u>text/call reminders</u> from our office?

___Guarantor's Phone Number

___Other Parent's Phone Number

___Other Phone Number:

_____

<u>Authorization for Voicemail Usage for PHI:</u>
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 <u>email address</u> would you like to be assigned as primary contact to receive <u>access to patient portal?</u>

___ 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 ☐ 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?

_____

New Patient Questionnaire

PART 2: FAMILY

Applicable Patient(s)

Last Name	First Name	Date of Birth

Household

Parent 1 Name: _____

Occupation: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

Parent 2 Name: _____

Occupation: _____

Height (in): _____

Glasses/Contacts? ☐ No ☐ Yes

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

Marital Status:

☐ Married ☐ Single

☐ Divorced ☐ Separated

☐ Other:

_____

Living Situation:

☐ Lives with both parents

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

☐ Lives with appointed guardian:

_____

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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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

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. Acknowledgement of this policy is required to receive treatment.

Insurance

It is your responsibility to familiarize yourself with the details of your insurance policy. It is your responsibility to confirm with your insurance carrier that GROW is considered to be "in-network" with your specific plan. Please refer to the Member Services phone number on your ID card. 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. As a courtesy, we will provide to you any information we have acquired requiring your specific benefits, and your estimated cost. Co-Pays are required to be paid at the time of service. ***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. In accordance with the No Surprises Act of 2022, you will be provided with a Good Faith Estimate from GROW prior to your appointment, provided that the appointment is scheduled 2 or more business days prior to the date of service. If you subsequently provide verifiable insurance information, ***and the time frame for billing the insurance has not expired*** (generally 45-90 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. Balances can be paid online on the GROW Intelichart Patient Portal (link can be found on our website) or by calling our office directly and choosing the option for the Front Desk. Accounts left outstanding with no good faith effort to resolve the balance will be sent to NHC Collections Agency. Once a patient account is in collections, GROW cannot take payment toward the balance in question. To arrange payment with NHC, please contact them at (877) 313-4138.

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 hours' 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, beginning with your family's second occurrence. In order to see each patient on time, it is our policy that your appointment will likely be rescheduled if you arrive more than 15 minutes late.

After Hours Phone Calls

Our office hours are Monday-Friday 8:00am-5:00pm. To utilize our After Hours nurse triage, please call our main number and follow the appropriate prompts. There is a $25 charge that will be billed to you for this service. Our triage service does have access to an on-call physician for urgent matters regarding such attention.

Saturday Visits

We charge an after-hours fee for physician visits held after regular business hours, such as Saturday clinic visits. This fee is $40 and is paid out of pocket, as it's generally not covered by insurance carriers.

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. My signature below also acknowledges my understanding and agreement to comply with this Financial Policy, as stated.

_____ _____

Parent/Guardian Signature Date

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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.

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative

Date

Printed Name of Parent/Legal Representative

Relationship to Patient

TEXAS Health and Human Services | 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**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

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

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.**