GROW Pediatrics & Adolescent Medicine, PLLC
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growpediatrics.com

NEW FAMILY DEMOGRAPHICS

Today's Date: ____________________ PCP: ____

How did you hear about us? ____

PATIENT INFORMATION

Patient 1 Name: ____
LAST FIRST MIDDLE

Nickname: ________________ Date of Birth: ______________ Gender: _____________

Patient 2 Name: ____
LAST FIRST MIDDLE

Nickname: ________________ Date of Birth: ______________ Gender: _____________

Patient 3 Name: ____
LAST FIRST MIDDLE

Nickname: ________________ Date of Birth: ______________ Gender: _____________

Address: ______________________________ City____________ State _____ Zip________

GUARANTOR INFORMATION (PARENT HOLDING INSURANCE)

Relationship to patient: ________________ Name____________________________________
LAST FIRST MIDDLE

Date of Birth _______________ Cell Phone ___________________ Work Phone ________________

Address (if different): __________________________ City __________ State _____ Zip________

Email: ________________________________ Employer: __________________________

Insurer: ____________________ Policy/Member ID: ______________ Group Number: ____________

ADDITIONAL PARENT INFORMATION (NOT INSURANCE SUBSCRIBER)

Parent: Name ____ Date of Birth: __________
LAST FIRST MIDDLE

Relationship to patient: ____

Address (if different): ______________________________ City ___________ State _____ Zip________

Cell Phone ______________ Work Phone _________________ Employer _______________________

Email: ____

FAMILY INFORMATION

Are the patient's parents divorced/separated? __________ If so, is custody shared? ____________

Is there a court ordered custody arrangement that limits one parent's medical decision making or access to child? If so, GROW requires a copy be kept on file. (please select one) **Yes / No**

GROW has a policy relating to family dynamics that clearly outlines boundaries/expectations surrounding communication, access to records and appointments, and parent responsibility. If this applies to your family, we'll be happy to provide you with a copy of this policy.

CONTACT OPTIONS

Which **phone number** should receive **text reminders** from our office?

____ Guarantor's Phone Number

____ Other Parent's Phone Number

____ Both

Authorization for Voicemail Usage for PHI:

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

Please initial to **ACCEPT:** ________

Which **email addresses** would you like to receive access to the **patient portal?**

____ Guarantor's Email

____ Other Parent's Email

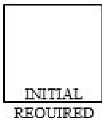
____ Both

PHARMACY INFORMATION

Preferred Pharmacy: ____ Phone: ___________________________________

Address/Cross Streets: ____

OFFICE VACCINE POLICY



I acknowledge that I am aware of GROW Pediatrics' Vaccine Policy. I understand that the details of the policy can be found on GROW's website, or in the office at any time. I agree to follow the practice's vaccine policy as long as my child(ren) remain patients of the practice.

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? ☐Yes ☐No
Reason: ___________________

Delivery: ☐Vaginal ☐Cesarean

Initial Feeding: ☐Formula ☐Breastmilk
How long breast fed? __________

Circumcision? ☐No or N/A ☐Yes
Date: ____/____/_____

At what age did your child learn to:
Walk? ______ Talk? ______

Has your child ever engaged in rehabilitative therapies? ☐ No

PT: ☐In the past ☐Currently
Reason: _____________

OT: ☐In the past ☐Currently
Reason: _____________

ST: ☐In the past ☐Currently
Reason: _____________

Does your child attend:
☐ Daycare?
____

☐ School?
____

For girls:
Has had first period? ☐Yes ☐No
Age of first period: ______

Any problems with her periods?
____

PART 2: FAMILY

APPLICABLE PATIENTS

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

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Living Situation:

☐ Lives with both parents, together.
☐ Separated parents with shared custody agreement.
☐ Lives with appointed guardian:
____

FAMILY HISTORY

From the patient's frame of reference, mark family members in the grid next to the 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							

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 REQUIRED

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	Relationship to Patient	Emergency Contact (check if yes)

TO PERMIT ONLY PARENT/GUARDIAN TO ACCOMPANY CHILDREN

INITIAL REQUIRED

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 AND OLDER)

INITIAL REQUIRED

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 Patient/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 National Healthcare Collections, LLC. 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

______________________________________ _________________________

Patient Name Date of Birth