Children’s Dermatology Services

MAIN Office:
11279 Perry Highway
Suite 108 Pine Center
Wexford, PA 15090

Secondary Office:
Children’s South
205 Miller Run Road, 3rd Floor
Bridgeville, PA 15017

Telephone (724) 933-9190
FAX (724) 933-9194
www.chp.edu/CHP/dermatology

Welcome to our practice!

Please partner with us by supporting the following Patient Visit and Treatment Policies which will help us to provide the best care for your child.

1. **Appointment Times/Visit** - Arrive 15 minutes in advance of your child’s scheduled appointment time and allow about an hour for the visit. Parents/patients who arrive 15 minutes later than their scheduled appointment time may need to reschedule. Generally our providers run on time and will do their best to see your child in a thorough but timely manner.

2. **Schedules** - We have several different providers whose schedules run simultaneously. While sitting in our waiting room, you may see a patient/parent who arrived after you getting called to an exam room before you do if they are seeing a different provider.

3. **Insurance Cards** - Our check-in staff must scan your insurance card at each visit.

4. **Treatment of Minors** - The State of Pennsylvania requires all patients under 18-years-of-age to be accompanied by a parent or legal guardian unless you, the parent or legal guardian, provide prior written consent for someone at least 18 years or older to accompany your child to the appointment and examination. Our check-in staff can provide you with a Medical Consent Authorization Form to permit someone other than the parent/guardian to be part of your child’s visit. **Note:** Procedures will be performed only when a parent or legal guardian accompanies the child (under 18 years-of-age) at the time of the visit. Also, the initiation of Accutane will occur only when the parent is present with the child (under 18 years-of-age) for the start-up visit.

5. **Prescription Refills** - Prescription refill requests will be considered only for those patients examined in the past six months or for those patients who are seen within the recommended follow up visit time, with the exception of patients on medications who need to be closely monitored. If your child has not been seen within these timeframes, call our office to schedule a return appointment.
Prescription refills called in after 3:00 pm will be processed, upon physician approval, the next business day.

6. **Number of Dermatology Conditions Treated Per Visit** - We strive to provide your child with exceptional patient care. In order to do this, we are happy to treat your child for up to two dermatologic conditions per visit.

**Appointment Cancellation and No Show’s** – Please call our office at least 48 hours in advance should you need to cancel or reschedule your child’s appointment. We have a No-Show Policy which states that failure to cancel an appointment within 24 hours or sooner to the appointment is considered a “no show”. After three no show appointments per family, that family is dismissed from our practice.

Please see our one of our front desk team members if you have any questions. **Thank you.**
Parent/Legal Guardian:

Thank you for choosing Children’s Dermatology and Acne Treatment Center for your child’s care. We strive to achieve the highest level of satisfaction in providing accurate and efficient care to you and your family.

We are more than happy to see your child in your absence, but for legal compliance, we do need the attached form, with your signature and whom you’re giving power to consent on your behalf, on file in our computer system, authorizing our providers to treat your child in your absence.

You can either mail this form back to our office, at the above address, or you can send it with your designated power of consent at the next appt.

If you have any questions or comment please do not hesitate to contact our office.

Sincerely,

Douglas Kress MD

Robin Gehris MD
# Patient's Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>D.O.B.</th>
<th>Gender</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th>Race</th>
<th>Patient resides with (please circle below):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mother</td>
</tr>
</tbody>
</table>

# Pediatrician /PCP

<table>
<thead>
<tr>
<th>Physician's Name</th>
<th>Office/Practice Name</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

# #1 Guardian/Parent

- [ ] Check here if this person is the insurance carrier

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Relationship</th>
<th>SS#</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>E-mail Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Employer</th>
<th>D.O.B.</th>
</tr>
</thead>
</table>

# #2 Guardian/Parent

- [ ] Check here if this person is the insurance carrier

<table>
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<th>City</th>
<th>State</th>
<th>Zip</th>
<th>E-mail Address</th>
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<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Employer</th>
<th>D.O.B.</th>
</tr>
</thead>
</table>

# Emergency Contact

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship to patient:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
</table>

PAYMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION:

I authorize the release of my medical information necessary to process insurance claims and request payment of insurance to Children's Community Pediatrics.

Signature: ___________________________  Date: __________/____/____

UPDATE: 11/8/2010  © 2010-2011 Children's Dermatology Services
PATIENT INFORMATION FORM

Children's Dermatology Services and Acne Treatment Center
Douglas W. Kress, MD
Robin P. Gehris, MD
Pine Center, Suite 108
11279 Perry Highway
Wexford, PA 15090
724.933.9190

Patient Name: ________________________________ Sex: Female / Male Patient Age: ____________
Date of Birth: ________________________________
Name of adult accompanying patient at today's visit: ____________________________________
Legal relationship of adult to patient being seen? ________________________________________
Is there a legal custody agreement in place for this patient? ____________________________
**If so, please provide us with any relevant paperwork.**

Reason (s) for today's visit: ☐ Acne ☐ Warts ☐ Molluscum ☐ Eczema ☐ Birthmark
☐ Mole Check/Removal ☐ Unknown Rash ☐ Hair Trouble ☐ Bleeding Lesion
Other: __________________________________________________________________________

List all your child's past and existing medical problems:
1) __________________________________________________________________________
2) __________________________________________________________________________
3) __________________________________________________________________________
4) __________________________________________________________________________

List all of your child's current medications;
Including all oral, topical, and over-the-counter products:
1) __________________________________________________________________________
2) __________________________________________________________________________
3) __________________________________________________________________________
4) __________________________________________________________________________
5) __________________________________________________________________________
6) __________________________________________________________________________

List all of your child's medication allergies: (Please list the patient's reaction to these allergies)
1) __________________________________________________________________________
2) __________________________________________________________________________
3) __________________________________________________________________________
4) __________________________________________________________________________
5) __________________________________________________________________________
Other: __________________________________________________________________________

FAMILY HISTORY
Has anyone in your family ever been diagnosed with any of these conditions? Please list family member:

I verify that the above information is accurate:
Parent/Legal Guardian Signature: _________________________________________________ Todays Date: __/__/____

I reviewed and transferred this information into this patient's Epicare record. Name: ____________________________
Print/Sign ____________________________ Date ____________________________

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AUTHORIZATION FOR PHOTOGRAPHY

Please INITIAL each blank AND circle “YES” or “NO” to the following:

I permit photography to be taken, if needed, at each Children’s Dermatology Services appointment for:

- For my child’s or for my own record to document the skin appearance at the medical visit
  - Yes
  - No (circle one)

- For academic teaching
  - Yes
  - No (circle one)

I authorize the Children’s Community Pediatrics, Inc (CCP) employee or his/her designee to photograph (still digital photo) the patient. I understand that CCP, and in some cases the organization with which it has partnered, has / shall have all legal rights to the photography and that I give up any and all rights to these organizations and will not receive any payment or compensation for the same now or in the future. I hereby release and discharge CCP, its subsidiaries, and its and their employees, agents, and representatives from any claims, liability, or results caused by the use of such photography of me as provided herein.

I understand that whether I choose to sign this authorization will in no way influence the health care services provided to me by CCP. Additionally, I understand that I will not receive any special services or compensation in exchange for my agreeing to sign this authorization.

I understand that I may revoke this authorization at any time by providing written notice to CCP addressed to: Children’s Dermatology Services Pine Center, Suite 108 11279 Perry Highway Wexford, PA 15090. However, such revocation shall not affect CCP’s right to use information, photography / recording(s), and / or interviews made or obtained prior to my revocation of this authorization.

Patient/Parent Signature: Date: ______________________________

(08/27/15)
Children's Hospital of Pittsburgh

Medical Consent Authorization
Act 52 of 1999 Medical Consent Act

I, ____________________________________________, am the Parent/Legal Guardian (if Legal Guardian, attach copy of court order) of the child(ren) listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

I, ____________________________________________, do hereby confer upon
(Name of Parent or Legal Guardian or Custodian)

(NAME OF PERSON BRINGING CHILD(REN) FOR CARE)

residing at __________________________

the power to consent to necessary medical or mental health treatment for the following child(ren):

1) Name: ___________________________ Born on: ________________
    Residing at: ___________________________

2) Name: ___________________________ Born on: ________________
    Residing at: ___________________________

3) Name: ___________________________ Born on: ________________
    Residing at: ___________________________

and on the child(ren)'s behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity.

The power that I confer is specifically limited to health care and mental health care decision making, and it may be exercised only by the person named above.

The person named above may consent to the following examinations and treatment for my child(ren) (check all that apply):

- [ ] Medical
- [ ] Surgical
- [ ] Mental Health
- [ ] Immunizations
- [ ] Development
- [ ] Dental
- [ ] Other (specify) ___________________________

and may have access to any and all records, including, but not limited to, insurance records regarding any such services (except as my be excluded under state and federal law.)
I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats or payments by any person or agency. This document (which consists of two pages) shall remain in effect until it is revoked by my written notification to my Child(ren)'s medical, mental health care, and insurance providers, and the person named above.

In witness whereof, I have signed my name to this medical consent authorization, on this _____ day of ____________, 20____ in ______________________, Pennsylvania.

________________________________________
(Printed Name) of Parent or Legal Guardian

________________________________________
(Signature) of Parent or Legal Guardian

________________________________________
(Witness Signature)

________________________________________
(Witness No. 1 Printed Name and Address)

________________________________________
(Witness Signature)

________________________________________
(Witness No. 2 Printed Name and Address)

________________________________________
(Signature of Adult Person who is Being Given Power to Consent)
Re: Personal Representative Designation Form

Dear Patient (18 years or older):

Thank you for choosing or continuing your care with Children’s Dermatology Services. Due to the federal HIPAA standards, in order for your parent/guardian to have access to your medical records at our office, and to schedule future appointments for you, we are required to have on file the completed attached Personal Representative Designation Form. Please complete this form and mail it to our office or bring it with you at your next appointment.

Thank you.

Sincerely,

Douglas Kress, MD

Robin Gehris, MD
This personal representative designation applies to the following UPMC entity/locations (list all applicable entities):

**REQUIRED INFORMATION:**

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>Patient's Date of Birth:</th>
<th>Patient's Medical Record Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Address</td>
<td>Patient's Phone Number:</td>
<td>Patient's Email:</td>
</tr>
<tr>
<td>Parent/Legal Guardian/Designee Name:</td>
<td>Parent/Legal Guardian/Designee Phone Number:</td>
<td>Parent/Legal Guardian/Designee Cell Phone Number:</td>
</tr>
<tr>
<td>Parent/Legal Guardian/Designee Address: (If different from patient)</td>
<td>Parent/Legal Guardian/Designee Email:</td>
<td></td>
</tr>
<tr>
<td>Name of Patient's Personal Representative:</td>
<td>Personal Representative Phone:</td>
<td></td>
</tr>
<tr>
<td>Personal Representative Address:</td>
<td>Personal Representative Fax:</td>
<td></td>
</tr>
<tr>
<td>Any limitations on issues your personal representative may discuss?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).

**REQUIRED SIGNATURES:**

Personal Representative Signature: _____________________________ Date: ___________

Patient Signature: _____________________________ Date: ___________

Parent/Legal Guardian Signature: _____________________________ Date: ___________

(If patient is a minor)

Please return this completed form by mail to: _____________________________

or by fax to: _____________________________

The original scanned form is to be placed in the Administrative Folder within the medical record with copies provided to the patient/family and the personal representative.