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 that 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.***

Children's Dermatology Services and Acne Treatment Center
Wexford, PA 15090
724-933-9190

NEW PATIENT REGISTRATION FORM
Please complete ENTIRE form

Patient's Information				
Last Name	First Name	MI	D.O.B. ___/___/___	Gender M or F
Language Race	Patient resides with (please circle below): Mother Father Both Other (Please Indicate)			

Pediatrician /PCP			
Physician's Name	Office/ Practice Name	Telephone Number	
Street Address	City	State	Zip

#1 Guardian/ Parent ☐ Check here if this person is the insurance carrier					
Last Name	First Name	MI	Relationship	SS# ___--___--___	
Street Address	City	State	Zip	E-mail Address	
Home Phone	Cell Phone	Work Phone	Employer	D.O.B. ___/___/___	

#2 Guardian/ Parent ☐ Check here is if this person is the insurance carrier					
Last Name	First Name	MI	Relationship	SS# ___--___--___	
Street Address	City	State	Zip	E-mail Address	
Home Phone	Cell Phone	Work Phone	Employer	D.O.B. ___/___/___	

Emergency Contact	
Name:	Relationship to patient:
Home Phone	Cell Phone

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: 09/10/15

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: _____
Date of Birth: _____ Sex: Female / Male Patient Age: _____
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 <u>past</u> and <u>existing</u> 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 rection 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:

1. Melanoma:____	5. Psoriasis: ____	9. Hair Loss/Alopecia: ____
2. Basal Cell Carcinoma: ____	6. Severe Acne: ____	10. Depression: ____
3. Squamous Cell Carcinoma: ____	7. Vitiligo: ____	11. Lupus: ____
4. Eczema: ____	8. Thyroid Problems: ____	12. Crohn's Disease: ____

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

Children's Community Pediatrics

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AUTHORIZATION FOR PHOTOGRAPHY

Patient Sticker

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)

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Medical Director, Pediatric Teledermatology
Children's Hospital of Pittsburgh of UPMC
Clinical Associate Professor of Dermatology & Pediatrics
University of Pittsburgh School of Medicine

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Physician Assistants:
Jaime Keenan, PA-C
Lauren Wright, PA-C
Courtney Geiger, PA-C
Valerie O'Connell, PA-C
Amy Dolnack, PA-C

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 parent/legal guardian signature and whom you are giving consent on your behalf for the office visit or any future visits to our office.

You can either mail this form back to our office at the above address or send it with your designated power of consent representative to the next appointment. We must have this completed form on file for your child's future appointments with the adult whom you have consented.

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

Sincerely,

Douglas KressMD/Robin Gehris MD

Children's Hospital of Pittsburgh

Medical Consent Authorization

Act 52 of 1999 Medical Consent Act

Form 3008 (7/05)

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)

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Re: Personal 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 HIPPA standards, in order for you 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,

Douglas Kress, MD

Robin Gehris, MD

Children's Hospital of Pittsburgh of UPMC

PERSONAL REPRESENTATIVE DESIGNATION FORM

CHP-00239 01/14

Patient Name

Medical Record Number

Birthdate

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

_____

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Medical Record Number:
Patient's Address	Patient's Phone Number:	Patient's Email:
Parent/Legal Guardian/Designee Name:	Parent/Legal Guardian/ Designee Phone Number:	Parent/Legal Guardian/ Designee Cell Phone Number:
Parent/Legal Guardian/Designee Address: (If different from patient)	Parent/Legal Guardian/ Designee Email:	
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:		
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.

00239

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Re: Medical Record Release Form

Dear Parent/Patient (18 years or older):

In order to process your medical record request, the following form must be completed. Please fill out the form in its entirety ensuring that you provide the complete mailing address of where you would like your records sent, and dates of records which you would like to be released. Once completed, please either fax the form to 742-933-9194 or mail it to our office.

Thank you,

Douglas Kress, MD

Robin Gehris, MD

UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

IMPRINT PATIENT IDENTIFICATION HERE

I authorize Children's Dermatology Services to release information from the record of:
Name of Facility/Person

Patient Name _____ Birth Date _____ SSN/MR# _____ to

Name of Facility/Person _____ ( ) Phone _____ ( ) Fax _____

Facility/Person Address _____

for the purpose of **(PROVIDE A DETAILED DESCRIPTION)**: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released **and** approximate date(s) of service (check all that apply):

O Inpatient O Emergency Dept. Dates: _____
O Outpatient O Physician Office/Clinic

I authorize the release of: (check all that apply) **O Mental Health Information** **O Drug and Alcohol Information, contained in the records indicated above.**

2. Specific information to be released (check all that apply):

O Consults
O Discharge Summary/Instructions
O Laboratory Reports/Tests
O Mammography Report
O Emergency Dept. Report
O Medical History & Physical Exam
O Medication Records
O Operative Report
O Pathology Report
O EKG Report(s)
O Physician Orders
O Progress Notes
O Psychiatric/Psychological Eval
O Radiology Report
O Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. **O Do not release**

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.** If applicable, specify other expiration date/event here: _____

Date/Time of Signature _____ Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.) _____ Date/Time of Signature _____ Signature of Parent, Legal Guardian or Authorized Representative* (complete below) _____

Date/Time of Signature _____ Witness/Staff Member Signature _____

***Authorized Representative's relationship and authority to act on behalf of patient:** _____

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date/Time _____ Witness #1 _____ Date/Time _____ Witness # 2 _____

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- UPMC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.
- I am entitled to a copy of this completed Authorization form.

Copy of authorization must be provided to patients when authorization is initiated by UPMC and for all Drug and Alcohol Treatment Patients.

O Copy of authorization provided to patient

O Copy of authorization refused

Staff and Copy Service Use Only (Optional)

Staff/Copy Service Signature: _____

O I.D. Obtained O Signature Checked O Other _____

Type of I.D.: _____

O Fee $_____ O No Fee

Records Release By: _____

Date Released: _____