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
Acne Treatment Center

An Affiliate of
Children's Hospital of Pittsburgh of UPMC

www.chp.edu/CHP/dermatology

Pine Center, Suite 108
11279 Perry Highway
Wexford, PA 15090

Ph: 724-933-9190
Fx: 724-933-9194

Douglas W. Kress, MD
Chief, Pediatric Dermatology
Children's Hospital of Pittsburgh
Clinical Associate Professor of Dermatology
University of Pittsburgh School of Medicine

Robin P. Gehris, MD
Chief, Pediatric Dermatologic Surgery
Medical Director, Pediatric Teledermatology
Children's Hospital of Pittsburgh
Clinical Assistant Professor of Dermatology & Pediatrics
University of Pittsburgh School of Medicine

Nisha C. Desai, MD, **Pediatric Dermatology Fellow**
Elizabeth Juhas, MD, **Pediatric Dermatology Fellow**
Amir Horev, MD, **Attending Physician**

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

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: 11/8/2010

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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and Acne Treatment Center
Pine Center, Suite 108
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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)

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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Valerie O'Connell, PA-C
Amy Dolnack, PA-C

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

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