Pediatric Alliance, P.C.
Division of Pediatric Endocrinology
Edgewood Towne Center
1789 South Braddock Avenue, Suite 294
Pittsburgh, PA 15218
Phone: 412-371-3000 Fax: 412-371-8128

Office Hours:
Monday: 8am – 6pm
Tues-Thur: 8am – 4pm
Fri: 8am – 12pm

Dear Parent(s),

Your child has an appointment with Dr. Rotenstein, M.D/ Kim Lynn, CRNP on

_____ at _____.
Please arrive 15 minutes early to allow time for registration and check in.
Enclosed are forms that need to be completed and brought to the appointment.
PLEASE COMPLETE ALL FOMRS PRIOR TO YOUR APPOINTMENT.

YOU MUST BRING THE FOLLOWING TO YOUR APPOINTMENT;

- Completed enclosed forms
- Your child's insurance card(s)
- Referral from your child's PCP, if your insurance requires one.
- Copies of your child's growth curve from PCP and/or specialist.
- Copies of blood work, if done
- Copies of x-ray and/or MRI reports, if done
- Your child's baby book, if available
- Heights and weights from your child's school, if possible

Please bring ALL of the above information with you the day of the appointment. **Do not rely on your child's PCP to forward the information to our office.** It is important to have the document with your child's scheduled appointment. This will help Dr. Rotenstein develop a treatment plan for your child in a timely manner; however further testing may need to be done.

FINANCIAL POLICY:
Payment is expected at the time of visit. You are required to pay any applicable co-pays set forth by your insurance at the time of the visit. Regardless of insurance, payment is your responsibility. There is a $10.00 charge if we bill for the co-pay. We accept cash, check and MC/Visa payments.

CANCELLATION POLICY:
Lack of notification limits our ability to accommodate the needs of other patients. Please cancel appointments 48 hours prior to the appointment as a courtesy o other patients who may be waiting for a cancellation.

Call our office with any questions or concerns at 412-371-3000.

Sincerely,
Office of Deborah Rotenstein, M.D.
Enclosures

Driving Directions to:
Edgewood Towne Centre
1789 South Braddock Ave.
Suite 294
Pittsburgh, PA 15218
Phone: 412-371-3000

From the North:

-From Beaver County and Route 65
Take Rt. 65 to I-279 South toward Pittsburgh
Follow Exit 6A to 376 East toward Monroeville
Take Exit 7, Swissvale
Turn left onto Monongahela Ave and right onto South Braddock Ave.
Edgewood Towne Centre will be on the left.

-From Route 28
Take PA-28 South toward Pittsburgh
Take Highland Park Bridge exit 6 on the left toward PA-28 S, Aspinwall
Merge onto Highland Park Bridge/ Blue Belt
Take PA-8 (route 8) South / Washington Blvd ramp
Turn slight right onto Washington Blvd/ Blue Belt.
Continue to follow PA-8
Turn left onto PA-380/PA-8/Penn Ave. Continue to follow PA-8/ Penn Ave.
Turn right onto South Braddock Ave. for 1.7 miles.
Edgewood Towne Centre will be on the left on

-From the North and Ohio Turnpike
Take PA Turnpike (1-76) to Exit 28, Cranberry/Pittsburgh.
Follow I-79 South and I-279 toward Pittsburgh.
Merge onto I-579 South via Exit 8A toward Veteran's Bridge.
Take Exit toward I-376 E/Oakland/Monroeville.
Stay straight to go onto the Blvd of the Allies
Merge onto I-376 E/ US-22 E/ US-30 E toward Monroeville.
Take Exit 7, Swissvale
Turn left onto Monongahela Ave and right onto South Braddock Ave.
Edgewood Towne Centre will be on the left.

From the South:

-From the South Hills and Liberty Tunnels
Take Rt. 51 South through the Liberty Tunnels
Travel across the Liberty Bridge.
Take the Blvd of the Allies ramp toward I-376 E/ Oakland/ Monroeville.
Turn slight right onto the Blvd of the Allies
Merge onto I-376 E/ US-22 E/ US-30 E toward Monroeville.
Take Exit 7, Swissvale
Turn left onto Monongahela Ave and right onto South Braddock Ave.
Edgewood Towne Centre will be on the left.

From the East:

-From Monroeville and PA Turnpike
Take PA Turnpike (I-76) to Exit 57, Pittsburgh
Follow I-376 West toward Pittsburgh
Take Exit 7, Swissvale
Turn left onto Monongahela Ave and right onto South Braddock Ave.
Edgewood Towne Centre will be on the left.

From the West:

-From the Airport and Fort Pitt Tunnels
Take I-279 North
Follow signs to Pittsburgh
Go through Fort Pitt Tunnels
After exiting the tunnel, get in the right lane and follow signs to I-376 East, Monroeville
Follow I 376 through the Squirrel Hill Tunnels
Take Exit 7, Swissvale
Turn left onto Monongahela Ave and right onto South Braddock Ave.
Edgewood Towne Centre will be on the left.

To get to our office located in the Edgewood Towne Centre Offices. Enter the office building and take the elevator to the 2nd floor make a left and we are located in suite 294.

Pediatric Alliance, PC

Administrative Office
1100 Washington Avenue, Suite 215
Carnegie, PA 15106

Dear Parents:

Welcome to our practice and thank you for choosing us as your child's/children's healthcare provider. We wish to advise all new parents of our policies and procedures to prevent any misunderstandings regarding our services.

- Please provide us with any previous medical records to ensure complete medical care.
- At your initial visit, you will be asked to complete a registration form. This form is to be updated when any changes occur to your insurance or personal information.
- You will be asked to present your insurance card at each visit.
- Payment of co-payments and non-covered services are expected at the time of service.
- If a co-payment is not made at the time of the appointment, a $10 fee will be assessed to each child's account.
- We will file a claim with your insurance carrier. Any amounts that are denied or unpaid will be billed to you.
- In divorce situations, the adult accompanying the child is responsible for payment at the time of service. The parent with whom the child resides is the parent who will be billed for services rendered. We cannot become involved in mediating financial arrangements between parents.
- Our fee for returned checks is $35.00. If two returned checks are received within any period of time, we reserve the right to request future services be paid with cash or credit card.
- Our appointment times are limited. Therefore we have an established fee for missed appointments. Our charge is $25.00 for a return visit and $50.00 for a new patient. Please call within 24 hours of the scheduled appointment to cancel.

We look forward to serving your child's healthcare needs. If you have any questions regarding these policies, please contact our office manager.

I have read and understand the above policies. I understand my responsibilities as stated above.

_____ _____

Signature of Responsible Party Date

Child/Children Names _____

Pediatric Alliance P.C.

CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT/GUARDIAN

I hereby give permission and written consent to Pediatric Alliance, PC, its physicians, employees, agents, and servants to render any and all medical treatment (including immunizations) as deemed necessary to my child(ren) listed below, who are minors, in my absence.

Patient Name:	**DOB:**

Select one:

☐ This permission applies to whomever accompanies my child(ren) to the office.

☐ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

☐ This permission applies to only the people who are listed below:

Parent/Legal Guardian
Signature: _____ Date: _____

Witness: _____ Date: _____

If the patient is a minor under 18 years of age, his or her consent is acceptable for the following reason(s):

☐ Married ☐ High school graduate ☐ Pregnancy/birth of child

OUR OFFICE POLICIES

Please read and keep for your records

PLEASE NOTE: If your insurance requires a referral to be seen, it must be in the office the day of the appointment or you may need to reschedule. It is your responsibility to obtain a referral from your primary care physician, not the offices!!!

APPOINTMENT TIMES:

* We request that you arrive 15 minutes **prior to** your actual scheduled appointment time to allow for registration and check in.

* Only if the patient is 18 years of age or older may he or she be seen without a parent or guardian. If you are unable to accompany your child please send a written note with the person coming with them to the appointment stating they are permitted to bring the child with your signature on the note. **Legally, we cannot accept the verbal permission of the person bringing the child.**

* We ask that you please limit your visit to parents and patients only in the exam room due to limited space. This places full focus on the patient and allows for best possible evaluation and management of you child.

LATE APPOINTMENT TIME ARRIVALS

In an effort to provide timely care to all of our patients, it may be necessary to reschedule an appointment if you arrive 15 minutes after the scheduled appointment time.

PRESCRIPTIONS/BLOOD WORK SLIPS

* Prior to each visit check to see if you need refills on medication and obtain all of the prescriptions at your office visit.

* Please be advised if you lose your prescription and one must be called to a pharmacy only a 7 day supply of medication will be called in. Within that time YOU will be expected to come to the office and pick up another prescription or mail a self-addressed stamped envelope and the prescription will be mailed. When calling our office to obtain a prescription, be aware that request made beginning at 3:30 pm will not be called in until the following business day.

* We no longer can mail out lost blood work slips. In the event that you lose a slip, you will have to come to the office for a new one or provide us with a fax number with 1 business day prior notice of where you need the slip faxed.

MAIL ORDER PRESCRIPTION

* It is the responsibility of the patient to send in their own mail order prescriptions.

TEST RESULTS

* Test results for new patients and outpatient and outpatient stimulation testing are reviewed at the first face to face follow up visit-not by phone. Normal test results from all other routine follow up visits are communicated by mail, only abnormal test results that require discussion will be called. Due to the large volume of labwork reviewed by our office if may take a number of weeks for notification.

OUTPATIENT TESTING

* We will schedule all stimulation testing, however you are required to schedule other tests such as MRI, ultrasound, x-ray, or Dexa scan. **You will need to notify our office with the date of this testing, facility name, and phone number prior to your test.** Insurance authorizations will be obtained by our office as required, however if your insurance requires a referral, you will be responsible for contacting the PCP to obtain this.

FORMS

* There will be a $5.00 fee for each form that must be completed by the physician and/or office personnel. **This fee is not covered by insurance.** Payment in full is expected at the time of the request. Please allow a minimum of 72 hours for completion. At the time you request this service, you will need to provide a phone number where you can be contacted, a fax #, or a self addressed stamped envelope to return the form. Physical forms for school or sports much be completed by your child's PCP.

* School forms requiring completion for administration of medication ordered by our office will be completed free of charge **once** during the school year. The completion of the INITIAL family medical leave form will be free of charge for conditions treated by our office. ALL other forms and family medical leave forms/paperwork will require the $5.00 fee. All forms will be completed using the above guidelines.

RELEASE OF RECORDS

* It is necessary to complete a release of record for the release medical records. This is a requirement by federal law. We can only release our records- we cannot legally release records received from another health care provider. By law, at the age of 18 the patient is required to complete this form not a family member. We require 30 days to process the request. The office will charge for copying of medical records for persons other than physicians providing medical care to the patient. This fee is due prior to the release of the records.

RELEASE OF INFORMATION

TO: PEDIATRIC ALLIANCE DIVISION OF ENDOCRINOLOGY
DR. DEBORAH ROTENSTEIN M.D.

To ensure proper and timely handling of your test results which have been ordered by our health care providers, in addition to being able to reach you during daytime hours, please provide us with the following information:

HOME # _____
WORK # _____
CELL # _____

****Of the numbers listed above, please indicate your FIRST choice for one of our staff members to reach you during normal business hours****

I authorize the above named physician or one of her associates employed by the medical practice to release any and/or all medical information relating to me/my child:

Please initial your choices that you agree to:

_____ May leave a message at work to call the office

_____ May leave a message on the answering machine/voice mail to call the office

_____ May leave a message on the answering machine/voice mail at home or on your cell phone regarding you or your childs test results or medical treatment

_____ May leave a message with any individual that would answer your home phone or cell phone

_____ I would only like my/my childs test results discussed ONLY with myself as a parent (or yourself if you are 18 or older)

_____ I would also like to designate another individual to accept test results in my absence

NAME: RELATIONSHIP: PHONE #

***I understand this release will be in effect unless changed or revoked by myself either in writing or by filling out a new release. ***

Today's Date: _____ Patient Name: _____

Home Address where CHILD Lives: _____

_____

Childs Date of Birth: _____ Relationship to Patient: _____

Signature: _____

PATIENT INFORMATION

Patient Name_____ Phone # (___) _____
First M. Last Cell # (___) _____
Date of Birth_____ Soc. Sec._____ Age_____ M___ F__
Address_____ City_____ State_____ Zip Code_____
Student? Y____ N____ If Yes, Name of School_____
Pediatrician / PCP_____ Phone # (___) _____
Address of Pediatrician / PCP_____
Who referred you?_____ Phone # (___) _____
Address of Referring Physician_____
Nearest Relative Not Living With You_____ Phone # (___) _____
Pharmacy Name_____ Phone # (___) _____

GUARANTOR INFORMATION

Father's Name_____ DOB:_____ SSN:_____
Address_____ Phone # (___) _____
Father's Employer_____ Phone # (___) _____
Mother's Name_____ DOB:_____ SSN:_____
Address_____ Phone # (___) _____
Mother's Employer_____ Phone # (___) _____
Other Guardian_____ DOB:_____ SSN:_____
Address_____ Phone # (___) _____
Guardian's Employer_____ Phone # (___) _____

INSURANCE INFORMATION

Name of Primary Ins. Co._____
Address of Primary Ins. Co._____
Subscriber_____ Policy #_____ Group #_____
Name of Secondary Ins. Co._____
Address of Secondary Ins. Co._____
Subscriber_____ Policy #_____ Group #_____
Name of Other Ins. Co._____
Address of Other Ins. Co._____
Subscriber_____ Policy #_____ Group #_____

Dr. Rotenstein
Pediatric Endocrinology

NAME_____ DATE OF BIRTH_____

REASON FOR COMING TO THE DOCTOR_____

_____

WHEN DID PROBLEM START?_____

HOW LONG DOES PROBLEM LAST(DURATION)_____

HOW SEVERE?_____

WHAT MAKES IT BETTER OR WORSE?_____

WHERE IS THE PROBLEM?_____

FAMILY HISTORY:

Mother's age_____ Father's age_____

Mother's height_____ Father's height_____

Age mother started periods____ Age father stopped growing_____ or shaved_____

Mother's father's height_____ Father's father's height_____

Mother's mother's height_____ Father's mother's height_____

SIBLINGS: BROTHERS(AGES) SISTERS(AGES)

_____ _____

_____ _____

DOES ANYONE IN THE FAMILY HAVE : DIABETES? Y N

THYROID DISEASE? Y N

MULTIPLE MISCARRIAGES? Y N

MEDICATIONS PATIENT IS TAKING:_____

ALLERGIES?_____

HOSPITALIZATIONS?_____

SURGERY?_____

HAS PATIENT HAD HEAD TRAUMA?_____

ARE IMMUNIZATIONS CURRENT?_____

Dr. Rotenstein
Pediatric Endocrinology

NAME_____ DOB_____ DATE_____

PRENATAL AND BIRTH HISTORY

PROBLEMS DURING THE PREGNANCY? Y N _____

MEDICATIONS DURING THE PREGNANCY? Y N _____
DID YOU DRINK WHILE PREGNANT? Y N _____
DID YOU SMOKE WHEN PREGNANT? Y N _____
WERE ANY DRUGS USED WHILE PREGNANT? Y N _____
ANY PROBLEMS WITH DELIVERY? Y - N _____
WAS YOUR CHILD PREMATURE? Y N _____
WERE THERE PROBLEMS AS A NEWBORN? Y N _____

BIRTH WEIGHT_____ BIRTH LENGTH_____
BREAST FED?_____ BOTTLE FED?_____

CHILD DEVELOPMENT: HOW OLD WAS YOUR CHILD WHEN THEY:

WALKED?_____
SAID FIRST WORDS?_____
FIRST TOOTH?_____
TOILET TRAINED?_____

WHO LIVES IN THE HOUSEHOLD WITH CHILD?_____

ARE PARENT(S): married / divorced / separated / single parent
ARE PARENTS EMPLOYED? Y N
WHAT GRADE IS YOUR CHILD IN SCHOOL?_____
WHAT GRADES DOES YOUR CHILD RECEIVE IN SCHOOL?_____
WHAT ARE CHILD'S INTERESTS OR HOBBIES?_____
WHAT EXERCISE DOES YOUR CHILD DO DAILY?_____
LIST WHAT YOUR CHILD EATS ON A TYPICAL DAY:
BREAKFAST: LUNCH: DINNER:

PARENT SIGNATURE_____ REVIEWED_____ DATE_____

Pediatric/Adolescent Social History

Patient Name:_____ **Date:**_____

Accompanied by:_____

Resides With:

Primary: Add Primary

Time spent: Secondary: Add Secondary

Time spent:

Tobacco Exposure:

Smokers at home?: ○ No ○ Yes

❖ Tobacco Cessation

Hand dominance:

○ Right ○ Left ○ Ambidextrous

Child Care:

Provider:	# days/week:
☐ Mother	
☐ Father	
☐ Grandparent	
☐ Sibling	
☐ Nanny	
☐ Daycare	
☐ Sitter	
☐ Self	
☐ Relative:	
☐ Neighbor/friend	

Daycare facility name:

Relationships:

Parent/guardian relationship	Occupation

Parents' marital status:

Cooperates with family/friends: ○ No ○ Yes

Cooperates with teachers: ○ No ○ Yes

Has enough friends: ○ No ○ Yes

Has friends of both sexes: ○ No ○ Yes

Concerns about relationship with family/friends/others: ○ No ○ Yes

Siblings: How many?: Birth order:

Relationship with sibling(s):

Home Environment:

Language spoken at home:

Neighborhood:

Housing Status:

Home type:

Home age:

Home affords adequate privacy: ○ No ○ Yes

Home affords adequate safety: ○ No ○ Yes

Water source: ☐ Municipal ☐ Well ☐ Bottle

Is water chlorinated?: ○ No ○ Yes

Is water fluoridated?: ○ No ○ Yes

Is there lead in home?: ○ No ○ Yes

○ Removed ○ Unknown

❖ Comments

Safety:

Uses bike/skating helmet: ○ No ○ Yes

Car restraints: ○ Car seat: face rear ○ Booster ○ None ○ Car seat: face front ○ Seat belt

Carbon monoxide detector: ○ No ○ Yes

Smoke detectors: ○ No ○ Yes

Radon in home: ○ No ○ Yes ○ Untested ○ Treated

Firearms in the home: ○ No ○ Yes ❖ Firearms

Pool/spa at home: ○ No ○ Yes

Pets/animals at home: ○ No ○ Yes

Education:

School name:

Grade in school:

Grades earned:

Learning disability?: ○ No ○ Yes

Special needs?: ○ No ○ Yes

Gifted program?: ○ No ○ Yes

Performing: ○ Below grade level ○ At grade level ○ Above grade level

Like school?: ○ No ○ Yes

Truancy?: ○ No ○ Yes

College prep? ○ No ○ Yes

High school graduate: ○ No ○ Yes

Pregnancy /Birth History

Maternal illness/complications Yes ☐ No ☐

☐ Gestational Diabetes ☐ Diabetes (NIDDM)

☐ Diabetes (IDDM) ☐ Pregnancy-induced HTN

☐ Hypertension ☐ Eclampsia ☐ Sickle cell disease

☐ Sickle cell trait ☐ Underlying cardiac disease

☐ Underlying renal disease ☐ Surgery during pregnancy

Labor and delivery

Type of delivery:

Time of birth: Hour: Mins: ○ AM ○ PM

Time of birth: Hours of labor: 0

Gestational age: wks days ☐ Premature

Birth weight: lbs oz 0.000 kgs

Length: in cm

Family History

		Who/ what kind?
ADD/ADHD	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Birth defects	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Coronary artery disease	☐ Yes ☐ No	
DDH (hip dysplasia)	☐ Yes ☐ No	
Deafness	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Developmental delay	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Eczema	☐ Yes ☐ No	
Genetic disorder	☐ Yes ☐ No	
Hemoglobinopathy	☐ Yes ☐ No	
Hyperlipidemia	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	
Learning disability	☐ Yes ☐ No	
Mental retardation	☐ Yes ☐ No	
Migraines	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Scoliosis	☐ Yes ☐ No	
Seizure disorder	☐ Yes ☐ No	
SIDS	☐ Yes ☐ No	
Strabismus	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	
Multiple Miscarriages	☐ Yes ☐ No	