

Welcome to UCP of Central Arizona Therapy

Therapy Information Packet Summary

Thank you for taking the time to complete and share the attached information with UCP's Therapy Department. All information attached will help us best serve and support your child and family.

Please fill out all forms in black ink.

General Information (page 1)

This page includes general information about your child including child's full name, date of birth, parent's name, etc. The page is required and to be completed in full and returned to UCP.

Medical/Developmental History and Preferences (pages 2 and 3)

These pages give us specific medical and developmental history of the child. Listing preferences helps the therapist to motivate your child and get to know them during the first session. These pages also include availability questions to assist with scheduling therapies.

Voluntary Information (page 4)

This page is voluntary information and will not be connected with your child's file. It is used for support in writing grants and applying for contracts. This form is optional but if it is completed, it is to be returned to UCP.

Consent to Use Insurance (page 5)

This page allows UCP to submit claims to your primary and secondary insurance company. If your child is eligible for the Division of Developmental Disabilities (DDD), it is a requirement within our DDD contract to bill the primary insurance first. A copy of your insurance card(s) (front and back) necessary to keep on file. The page is required and to be completed in full and returned to UCP.

General Consents (pages 6, 7, 8, and 9)

These consents are used to allow UCP's Therapy Department to connect with professionals who also support and help your child. People or professionals include but are not limited to: Primary Care Physician, Medical Specialists, Family Members, Caregivers, and Respite/Habilitation Providers who are participating in therapy sessions, Childcare, School Team, etc. At minimum UCP needs permission to communicate with your child's PCP in order to coordinate therapy services and other recommended referrals.

****For consents for PCP, the Authorization to Disclose AND Consent to Share will need to be completed. For others like Respite, Habilitation, or School, the Consent to Obtain AND Consent to Share will need to be completed. If you need additional forms, please ask the front desk or your therapist directly.**

Notice of Privacy Practices (pages 10 and 11)

The Notice of Privacy Practices explains your rights for your child and how their protected health information is managed. The first form is your copy to keep and the second is for you to sign and is required to be completed in full and returned to UCP.

Attendance Policy (page 12 and 13)

This form is used to share UCP's Therapy Program Attendance Policy and General Expectations. Page 12 is for you to keep in your child's file and page 13 (the signed copy) is to be returned to UCP.

Service Agreements (page 14)

This form is your acknowledgement and consent of UCP's policies related to permission to treat, attendance, medical emergency, and media release. This form is required to be completed in full and returned to UCP.

**Thank you for taking the time to complete our forms. If you have any questions, please contact our
Clinic Therapy Manager, Laura Zilnik:**

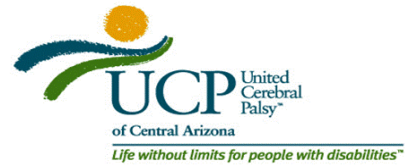
Lzilnik@ucpofcentralaz.org (602) 682-1893

Laura Dozer Center: 1802 West Parkside Lane Phoenix, AZ 85027

UCP Downtown: 1007 North 7th Street Phoenix, AZ 85006

Office: 602-943-5472 Fax: 602-944-1658

Updated December 2016



Welcome to UCP of Central Arizona Therapy

Child's Information

Name: _____ Male: ___ Female: ___ Date of Birth: _____
Nickname: _____ Language Preference: _____
Home Address (include city, state, zip): _____
Mailing Address (if different from above): _____

Responsible Party

Mother/Guardian Name: _____ Email Address: _____
Cell: _____ Alternate Number: _____
___ Check here if mother's/guardian's address is the same as child's
Address if not same as child's: _____
Preferred Method of Contact (Circle One): Phone/Voicemail-----Text-----Email-----Mail

Responsible Party

Father/Guardian Name: _____ Email Address: _____
Cell: _____ Alternate Number: _____
___ Check here if father's/guardian's address is the same as child's
Address if not same as child's: _____
Preferred Method of Contact (Circle One): Phone/Voicemail-----Text-----Email-----Mail

How did you hear about UCP of Central of Arizona? (check all that apply)

Friend___ School___ Physician___ Social Media/Internet___ Other___
Name of Referral Source (Optional): _____

What Services are you seeking or interested in? (check all that apply)

Speech Therapy___ Occupational Therapy___ Physical Therapy___ Feeding Therapy___

Have you received therapy services in past? ___Yes ___No

If yes, where and when? _____

Are you currently receiving therapy services? ___Yes ___No

If yes, which services and where? _____

Primary Care Physician

Primary Doctor's Name: _____ Office Name: _____
Location of Office: _____
Office Number: _____ Fax Number: _____

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Welcome to UCP of Central Arizona Therapy

Medical History

Current Medications (related to ADHD, reflux, behavioral, etc): _____

Medicine Allergies: _____

Diet Restrictions: _____

Food Allergies: _____

Movement Restrictions: _____

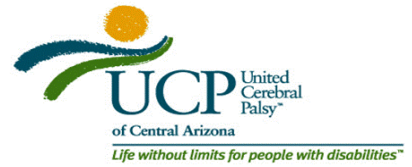
Previous Surgeries/Procedures: _____

Does your child have a Diagnosis? Yes No

If yes, what is the Diagnosis? _____

Family Medical History/Diagnosis related to child's diagnosis: _____

Yes	No	Current Medical Problems:	Explanation if Yes:
		Recurrent ear Infections	
		Recurrent colds or sinus infections	
		Recurrent Ulcers in mouth	
		Frequent choking or gagging	
		Chronic or recurrent cough	
		Pneumonia	
		Wheezing	
		Heart Problems	
		Nausea or abdominal pain	
		Vomiting, frequent spitting up, or regurgitation	
		Bowel Problems ___ Constipation ___ Diarrhea	
		Changes in urination ___ Increase ___ Decrease	
		Abnormal muscle tone (spasticity or hypotonia)	
		Seizures	
		Developmental Delay (speech, motor skills)	
		Sensory issues (lights, noise, movement, feel/touch)	
		Fractures or broken bones	
		Skin problems (eczema, rash, or breakdown)	



Welcome to UCP of Central Arizona Therapy

Developmental History

Gestational Age: _____

Birth Weight: _____

Post-Natal Complications: _____

At what age did your child: Roll _____ Sit Independently _____ Crawl _____ Walk Independently _____
Babble _____ Feed self _____ Dress Self _____ Toilet Self _____ (If not yet achieved write N/A)

Availability

Does your child attend school? __ Yes __ No

If Yes, What is their school schedule? _____

What are the best days/times for therapies? _____

Does your child take naps? __ Yes __ No

If Yes, What is their typical naptime? _____

Preferences

What is your child best motivated by (game, stickers, food, praise, etc.)? _____

Favorite Movies/TV shows: _____

Favorite Characters: _____

Other preferences/unique characteristics: _____

Communication/Language

How does your child communicate? __points/gestures __Signs __Verbal __PECS __Aug. comm. Device

Other: _____

What languages are spoken at home? _____



Welcome to UCP of Central Arizona Therapy

Voluntary Information:

UCP services are partially funded by community grants which often require information on those we serve. By completing the following you help us gather demographic data that will support our efforts. Thank you!

Household Size:

Total Living in Home: _____ # of Adults: _____ # of Children: _____

Ethnicity:

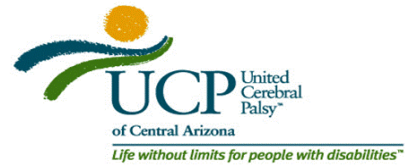
_____ American Indian or Alaska Native	_____ Hispanic or Latino
_____ Asian Pacific Islander	_____ Native Hawaiian or Other
_____ Black or African/American	_____ White
_____ Unknown	

Annual Household Income:

_____ Up to \$14,999	_____ \$15,000 - \$19,999
_____ \$20,000 - \$24,999	_____ \$25,000 - \$29,000
_____ \$30,000 - \$34,999	_____ \$35,000 - \$39,999
_____ \$40,000 - \$49,000	_____ \$50,000 or more

ZIP CODE:

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Consent to Use Insurance

Child's Name: _____ Date of Birth: _____

Division of Developmental Disabilities (DDD) and Arizona Long Term Care (ALTCS)

Do you have a DDD Service/Support Coordinator? Yes No ALTCS Eligible? Yes No

If Yes, Name of Service/Support Coordinator: _____

Phone Number: _____ Email: _____@azdes.gov

Private Pay Options

Check here if you elect to pay out-of-pocket for Therapies. **Payment is due on the date of service.**

We accept Cash, Check, Debit, MasterCard, VISA, American Express, and Discover.

Private Pay cost is \$250 for therapy evaluations and \$100 per one-hour therapy session.

Please contact us for private pay packages and/or scholarship opportunities.

Primary Insurance Information:

Insurance Carrier: _____ Health Plan, if applicable: _____

Insurance ID#: _____ Policy Group #: _____

Name of Policyholder: _____ Policy Holder's Date of Birth: _____

Relationship to Child: _____ Policyholder's Employer: _____

Claims Address: _____ Phone #: _____

Secondary Insurance Information:

Insurance Carrier: _____ Health Plan, if applicable: _____

Insurance ID#: _____ Policy Group #: _____

Name of Policyholder: _____ Policy Holder's Date of Birth: _____

Relationship to Child: _____ Policyholder's Employer: _____

Claims Address: _____ Phone #: _____

Verification of Benefits, Consent to Use Insurance, and Release of Information

I hereby certify that the information provided is true and correct.

I authorize UCP of Central Arizona (UCP) to use the above information to verify my insurance benefits to determine coverage of services. I understand that my insurance benefits are determined by the contract I hold with my insurance company and the request for prior authorization does not guarantee payment for therapy.

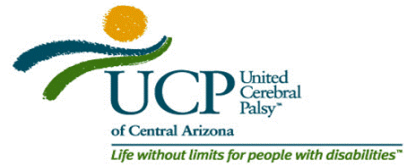
I understand that I am responsible for all fees and will be charged for any and all treatment not paid by the insurance carrier, for families that do not hold a DDD or AZEIP contract. I understand that co-pays/deductibles/co-insurance must be paid on the date of service (private insurance/self-pay only). If you are not able to pay at the time of service please speak to the clinic manager to arrange a payment plan.

I give consent for UCP of Central Arizona to bill my insurance for agreed upon therapy services.

I understand this consent allows UCP of Central Arizona to release and share information with my insurance company to assist in obtaining authorizations and payment of claims.

Signature of Responsible Party

Date



Welcome to UCP of Central Arizona Therapy

Consent to Share Records and Information

Child's Full Name

Date of Birth

Records and Information Authorized to Share (check all that apply):

____ Therapy Evaluation Reports

____ Therapy Prescriptions

____ Therapy Daily Notes

____ Medical Records /Docs

____ Therapy Process/Quarterly reports

____ Home Programming/Coaching/Strategies

____ Other (specify): _____

I, _____, give my informed consent for UCP of Central Arizona to release and
Parent/Responsible Party

Share my child's information identified above (in writing and/or conversation) to the following person/agency:

Person or Agency

Name of Person or Agency

Address in Full

Phone

Fax

Release of Records and Information

I have read and understand the conditions of this release. I understand I have agreed to disclose the information only to the person/agency listed above, and that the person/agency may not disclose the information to anyone else without my prior written consent. I understand that this consent can be revoked at any time but will automatically expire one year from the date of consent.

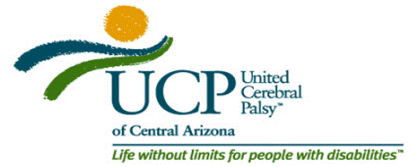
Name of Parent/Responsible Party

Relationship to Child

Signature of Parent/Responsible Party

Date

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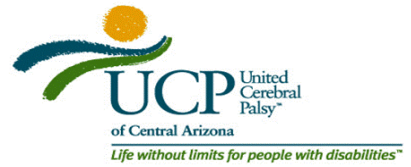
Name of Parent/Responsible Party

Relationship to Child

Signature of Parent/Responsible Party

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Welcome to UCP of Central Arizona Therapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Child's Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of UCP's Notice of Privacy Practices ("Notice"). The Notice provides information about how UCP may use and disclose your protected health information. UCP encourages you to read it in full. UCP's Notice is subject to change. If changed, it will be available on request from UCP's offices and on its website. If you have any questions or wish to obtain a copy of any revised Notice, please contact UCP via information provided below:

Attention: Privacy Officer
United Cerebral Palsy of Central Arizona
1802 West Parkside Lane
Phoenix, AZ 85027
O: 602-943-5472 F: 602-943-4936

By signing below, I acknowledge receipt of UCP's Notice of Privacy Practices:

Signature of Responsible Party

Date

Printed Name of Responsible Party

Relationship to Child

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain the below patient's acknowledgement of his or her receipt of UCP's Notice, including the attempts described below. Despite the following attempts _____

UCP was unable to obtain the patient's acknowledgement because _____

Signature of UCP's Responsible Party

Date

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UCP of Central Arizona Patient Rights

Under Arizona Administrative code R9-10-1008, A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 2-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Complaints

**To file a complaint please contact the
UCP Privacy Officer at
602-943-5472**

**Mailing Address:
1802 West Parkside Lane
Phoenix, AZ 85027**

OR

**The Arizona Department of Health Services
602-364-3030
1501 North 18th Avenue, Suite 450
Phoenix, AZ 85007**

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Welcome to UCP of Central Arizona Therapy

UCP Therapy Attendance Policy

Our Commitment to You

Due to the nature of therapy services, our therapists strive to give each child and family the time and attention they need. We are grateful for your patience and understanding when available time slots may not meet your expectations or needs. We will attempt to serve all family's needs equally.

Attendance Policy

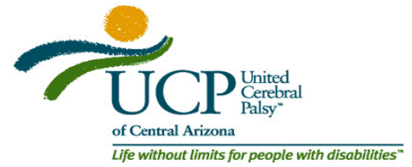
UCP of Central Arizona is dedicated to providing high quality of services. Your scheduled appointment time is very important to us so we may maximize the level of success with your child's plan of care.

We understand issues may arise that interfere with scheduled appointments, however, we do require a 24-hour cancellation notice or a fee may be applied. Please contact your child's therapist(s) directly to cancel an appointment. You may also contact our office at 602-943-5472 ext. 1844 to report any need to reschedule or cancel an appointment. Below are definitions pertaining to attendance and your expected responsibility for communicating with our office:

- ILLNESS/SICK:** If your child is not well, they will not benefit from the scheduled therapy session(s). If your child has had a fever over 100°F or has had an infection in the 24 hours prior to the appointment, your child is ill. As a courtesy to your therapist and the other children and families UCP serves, you will need to cancel your appointment(s). The appointment(s) will be rescheduled if possible.
- CANCELLATION:** A cancellation is defined as communicating with UCP of Central Arizona, canceling a scheduled appointment with a minimum of 24-hour notice. The appointment will be rescheduled if possible. If cancellations exceed 2 scheduled appointments within a 4 week period, it may result in the discontinuation of services or a loss of the scheduled time for recurring appointments. Cancellations due to illness will not be penalized. Excessive cancellations due to illness may require a doctor's note.
- LATE CANCEL:** A late cancellation is defined as communicating with UCP of Central Arizona, canceling a scheduled appointment with LESS than 24-hour notice. In this case you may be responsible for a late cancellation charge. The appointment will be rescheduled if possible.
- LATE ARRIVAL:** A late arrival is defined as arriving after your scheduled appointment time. In the event there is a conflict that will prevent you from arriving on time, we request you notify UCP of Central Arizona as soon as you can safely do so. All attempts will be made to deliver the scheduled service within the remaining time of your scheduled appointment. You may be responsible for a late cancellation charge if we are unable to provide the scheduled service in the time remaining once you arrive.
- NO-SHOW:** A no-show is defined as missing a scheduled appointment without notifying UCP of Central Arizona prior to your scheduled appointment time. If there are 2 no-shows for a scheduled appointment within a three month period, it may result in the discharge services or a loss of the scheduled time for recurring appointments. You may also be responsible for a cancellation fee.

Please keep in mind that when appointments are missed, 3 people are affected: Your child, since they don't get the treatment they need as prescribed by the therapist, the therapist, since they now have a space where your child's appointment was reserved, and another child who could have been scheduled for therapy if our clinic was given the proper notice.

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Welcome to UCP of Central Arizona Therapy

UCP Services Agreement

Child's Name: _____ Date of Birth: _____

UCP Expectations of Parent/Caregiver

To serve your child most effectively, it is the expectation that the parent/caregiver participate in all scheduled therapy sessions. This will allow your therapist to develop a better understanding of your concerns and your child's needs, implement a home program, and adhere to legal liability standards.

Following the initial evaluation process, ongoing therapy session participation will be determined by the therapist and parent/caregiver as to the extent of the presence in the room or viewing the session through the window.

If a parent or caregiver cannot attend a scheduled therapy session, the appointment will need to be rescheduled. Please communicate availability for a parent/caregiver to be present for all sessions with your child's therapist. Follow the clinic cancellation policy for cancelling and rescheduling appointments if this situation arises.

If your child participates in other UCP programs at the Laura Dozer Center and you are looking for therapy options while they are present for another program, please contact the therapy clinic manager for scheduling options to ensure a caregiver is present for all therapy sessions.

Payment Policy

_____ I understand that all payments are due within 30 days of receipt of statement. Services may be suspended until payment in full is received.

Patient Rights

_____ I acknowledge that I have received a copy of the UCP of Central Arizona Patient Rights.

Consent for Treatment

_____ I authorize UCP of Central Arizona to provide therapy services for my child.

Attendance Policy

_____ I acknowledge that I have received a copy of the UCP of Central Arizona Attendance Policy.

Emergency Medical Authorization

_____ I authorize UCP of Central Arizona staff to secure medical services in case of any medical emergency.

_____ I authorize UCP of Central Arizona staff to initiate any medical procedure necessary for safety/survival (CPR and Basic First Aid).

_____ I agree to be responsible for any fees necessitated by medical services secured by UCP of Central Arizona staff.

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Media Release

UCP of Central Arizona may take, use, or release photographs, video and/or audio information for various purposes. These can include the following: education and/or coaching purposes to share with parents and/or caregivers, justification for equipment recommendations and acquisitions, education and/or training purposes for other team members and/or UCP staff, grant allocations, media purposes such as newspaper, television, publications, etc. No royalty fee or other compensation of any nature will be payable by reason of such release.

Please initial below as acknowledgement of your agreement for each potential release

- _____ Education and/or coaching purposes to share with parents and/or caregivers
- _____ Justification for equipment recommendations and acquisitions
- _____ Education and/or training purposes for other team members and/or UCP staff
- _____ Grant allocations
- _____ Media purposes such as newspaper, television, publications, etc.
- _____ NO PERMISSION GRANTED

Authorization and Signature

I certify with my signature below that I have granted Consent to Treat, received a copy of the Attendance Policy, and completed the Emergency Medical Authorization and Media Release sections. I have received copies of and/or consultation regarding the above information related to the Therapy Services to be provided through UCP of Central Arizona.

Parent or Guardian Signature

Date

UCP Team Member Signature

Date