Welcome to UCP of Central Arizona Clinic 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 and 7)

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 must 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 and Patient Rights (pages 8 and 9)

The Notice of Privacy Practices explains where to access UCP's HIPAA Notice of Privacy Practices and explains patient right as outlined by the Arizona Department of Health Services.

Attendance Policy (page 10)

This form is used to share UCP's Therapy Program Attendance Policy and General Expectations. Please keep this page for your reference. Your signature acknowledging our attendance policy is required on the services agreement page.

Service Agreement and Media Release (pages 11 and 12)

This form is your acknowledgement and consent of UCP's policies related to payment policy, patient rights, consent to treat, attendance policy, and emergency medical authorization. This form is required to be completed in full and returned to UCP. The media release is an optional form allowing UCP to use media involving your child for various purposes.

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: _____

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 tome (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)	

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? _____

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	____	Native Hawaiian or Other Pacific Islander
___	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:

_____

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

Authorization to Disclose Protected Health Information

_____ _____

Child's Full Name Date of Birth

Protected Health Information Authorized to Disclose to UCP of Central Arizona (check all that apply):

____Physician Records ____Hearing/Audiology Reports ____Therapy Prescriptions

____Diagnosis ____Vision Reports ____Therapy Reports

____Diagnostic Testing Results/Reports ____Other (specify):_____

I, _____, give my informed consent for the following medical entity:
Parent/Responsible Party

Medical Entity (Primary Care Physician/Specialist/Hospital/Therapy Clinic)

_____

Name of Person or Agency

_____

Address in Full

_____

Phone Fax

To release and share medical information identified above (in writing and/or conversation) regarding my child with **UCP of Central Arizona**.

Release of Medical Records and Medical Information to UCP of Central Arizona

I have read and understand the conditions of this release. I understand I have agreed to disclose the medical information only to the UCP of Central Arizona, and that the medical entity may not disclose the medical 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

Please send records to UCP of Central Arizona

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Child's Name: _____ Date of Birth: _____

UCP's HIPAA Notice of Privacy Practices are available on UCP's website through the following link:
https://ucpofcentralaz.org/about-us/hipaa-notice-of-privacy-practices/
A printed copy can be provided upon request.

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

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

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. **Please call (602) 313-8830 to cancel and reschedule your child's therapy appointment**. **You may cancel and reschedule an appointment via text message at (928) 985-0643.** 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) and reschedule for a later date.

CANCELLATION: A cancellation is defined as communicating with UCP of Central Arizona, canceling a scheduled appointment with a minimum of 24-hour notice. Please work with clinic administration to reschedule the missed appointment. 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. Please work with clinic administration to reschedule appointment.

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.

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 of services or a loss of the scheduled time for recurring appointments.

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.

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.

_____ _____

Parent or Guardian Signature Date

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