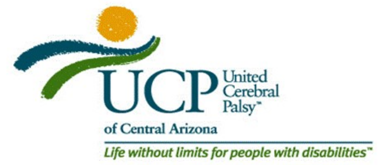
Mail to:
UCP of Central Arizona
Laura Dozer Center Therapy Clinic
1802 W. Parkside Lane, Phoenix, AZ 85027

Contact:
UCP Therapy Referral Team
P: 602-682-1844 l F 602-944-1658l therapyreferrals@ucpofcentralaz.org



Welcome to UCP of Central Arizona!

UCP of Central Arizona Baby Intake Packet

BABY AND FAMILY INFORMATION

Baby's Name: ____ Date of Birth: _____________________

Home Address ____
(include city, state, zip)

Responsible Party

1st Parent Name(s): _________________________________Email Address: _____________________________

Cell: _________________________________ Alternate Number: ____

Check here if address is the same as the baby ☐

If address NOT the same as baby:____
(include city, state, zip)

Preferred Method of Contact: Phone/Voicemail ☐ Text ☐ Email☐ Mail ☐

2nd Parent Name(s): _________________________________Email Address: _____________________________

Cell: _________________________________ Alternate Number: ____

Check here if address is the same as the baby ☐

If address NOT the same as baby:____
(include city, state, zip)

Preferred Method of Contact: Phone/Voicemail ☐ Text ☐ Email☐ Mail ☐

Primary Care Physician

Primary Doctor's Name: ___________________________ Office Name: __________________________________

Medical Specialists

Medical Specialist's Name: ______________________________ Office Name: ____________________________

Medical Specialist's Name: ______________________________ Office Name: ____________________________

Family Availability and Location Preference

What is the best time and place for therapy appointments?

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ | Mornings ☐ Afternoons ☐

UCP Downtown-East Clinic ☐ Laura Dozer North Valley Clinic ☐ Teletherapy ☐

Who will bring your baby to therapy evaluations and appointments? _____________________________________

Our UCP Team is looking forward to meeting you and your baby. You can send these forms by mail, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844.

Medical Information

Expected Date of Delivery: _______________ Length of NICU Stay: __________________________________

Does your baby have a new diagnosis(es) since NICU discharge Yes ☐ No ☐ If Yes, list the diagnosis(es):

____

Current Medications after NICU Discharge: ____

____

Recent Surgeries/Procedures after NICU Discharge: ____

Has your baby received an evaluation by the Arizona Early Intervention Program (AzEIP)?

If Yes, Name of Support Coordinator: ____

Phone Number: __________________________ Email: ____

Development Information

What are your concerns for your baby? ____

____

____

____

Please indicate if there are any *new* concerns for your baby since discharge:

Yes	No	Current Medical Problems	Explanation if Yes
☐	☐	Vision	
☐	☐	Hearing	
☐	☐	Breathing	
☐	☐	Feeding or swallowing	
☐	☐	Heart	
☐	☐	Stomach	
☐	☐	Bowel problems: ____ constipation ____ diarrhea	
☐	☐	Changes in urination: ____ increase ____ decrease	
☐	☐	Sleep habits	
☐	☐	State Regulation ___irritable ____content	
☐	☐	Muscles ___floppy ___stiff	
☐	☐	Seizures	
☐	☐	Skin problems ____eczema ____ rash	

CONSENT TO USE INSURANCE

Child's Name: ____ Date of Birth: ______________________

Private Pay Options

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

Primary Insurance Information

Insurance Carrier: __________________________________Health Plan, if applicable: ________________

Insurance ID#: ______________________________ Policy Group #: ______________________________

Name of Policyholder: ________________________________Policy Holder's Date of Birth: ____________

Relationship to Baby: ___________________ 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. 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 Therapy Program 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 Parent/Responsible Party *Date*

____

Relationship to Child

Our UCP Team is looking forward to meeting you and your baby. You can send these forms bymail, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844.

CONSENT TO DISCLOSE AND RECEIVE PROTECTED HEALTH INFORMATION

Child's Full Name _______________________ Date of Birth _______________

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

Physician Records ☐ Hearing/Audiology Reports ☐ Therapy Prescriptions ☐

Diagnosis ☐ Vision Reports ☐ Therapy Evaluations and 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

____
Complete Address (include city, state, zip)

____
Phone Fax

I authorize the sharing of 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 the sharing of medical information with the aforementioned entity with UCP of Central Arizona. 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*

Our UCP Team is looking forward to meeting you and your baby. You can send these forms by mail, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844.

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:

____ ________________________

Name of Parent/Responsible Party *Relationship to Child*

____ ________________________

Signature of Parent/Responsible Party *Date*

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 (FOR PARENT/GUARDIAN RECORDS)

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
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

By signing below, I acknowledge receipt of UCP's Patient' Rights:

_______________________________ _______________________________

Name of Parent/Responsible Party *Relationship to Child*

_______________________________ _______________________________

Signature of Parent/Responsible Party *Date*

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UCP THERAPY SERVCES 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 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 program manager for scheduling options to ensure a caregiver is present for all therapy sessions.

Payment Policy

____ When applicable, 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.

____ I understand that the therapy evaluation or initial appointment will determine the need for ongoing therapy services as described in the Plan of Care.

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

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