Laura Dozer Center Therapy Clinic:
1802 W. Parkside Lane, Phoenix, AZ 85027

UCP Downtown-East Therapy Clinic@ Ability 360:
5025 E. Washington St., Ste 108, Phoenix AZ 85034

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

UCP United Cerebral Palsy of Central Arizona
Life without limits for people with disabilities™

POSSIBILITIES REALIZED.™

UCP Therapy Program Annual Update Intake Packet

CHILD AND FAMILY INFORMATION

Child's Name: _____ Date of Birth: _____

Home Address _____
(include city, state, zip):

Responsible Party

Parent Name(s): _____ Email Address: _____

Cell: _____ Alternate Number: _____

Check here if address is the same as the child's ☐

If address NOT the same as child's: _____
(include city, state, zip)

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

Primary Care Physician

Primary Doctor's Name: _____ Office Name: _____

Office Number: _____ New ☐ Ongoing ☐

Medical Specialists

Specialist's Name: _____ Office Name: _____

New ☐ Ongoing ☐ Consent on File ☐

Specialist's Name: _____ Office Name: _____

New ☐ Ongoing ☐ Consent on File ☐

Are you interested in additional services at UCP? (Check all that apply)

Speech Therapy☐ Occupational Therapy ☐ Physical Therapy ☐ LIFE Group ☐ Feeding Therapy ☐

Medical Updates

Does your child have an updated or new diagnosis(es) Yes ☐ No ☐ If Yes, what is the diagnosis(es):

_____

_____

Current Medications: _____

_____

Medicine Allergies:_____

Food Allergies:_____

Diet Restrictions:_____

Movement Restrictions:_____

Recent Surgeries/Procedures:_____

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844

Does your child have any new medical updates?

Yes	No	Current Medical Problems	If Yes, explain
☐	☐	Vision	
☐	☐	Hearing	
☐	☐	Respiratory (i.e., breathing)	
☐	☐	Eating or swallowing	
☐	☐	Heart	
☐	☐	Abdominal	
☐	☐	Bowel problems: ____ constipation ____ diarrhea	
☐	☐	Changes in urination: ____ increase ____ decrease	
☐	☐	Abnormal muscle tone (spasticity or hypotonia)	
☐	☐	Seizures	
☐	☐	Fractures or broken bones	
☐	☐	Skin problems (eczema, rash, or skin breakdown)	

School Updates

Does your child attend school? Yes ☐ No ☐ If Yes:

Name of School: _____

Name of School District: _____School Hours: _____

Availability Updates

What are the best days and times for therapy sessions and make-up sessions:

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

What location do you prefer for therapy?

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

Does your child take naps? Yes ☐ No ☐

If Yes, what is their typical naptime? _____

Do you have reliable transportation for therapy appointments? Yes ☐ No ☐

Who will bring your child to therapy evaluations and appointments? _____

Therapy Updates

Are you looking for additional therapy for your child?

Speech Therapy☐ Occupational Therapy ☐ Physical Therapy ☐ LIFE Group ☐ Feeding Therapy ☐

Is your child currently receiving therapy services at another location? Yes ☐ No ☐

If Yes, where? Name: _____

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Voluntary Information: UCP of Central Arizona 2021 Demographic Page

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!

Programs enrolled in at UCP (check all that apply)

Early Learning Center (ELC) ☐ UCP Downtown-East Therapy Clinic ☐

Laura Dozer Therapy Clinic ☐ Home Community Based Services (HCBS) ☐

Day Training Program (DTA) ☐

How long has the child or the adult member been enrolled with UCP?

Less than 1 year ☐ 1 – 3 Years ☐ 3 – 5 Years ☐ More than 5 years ☐

Number of Programs/ Services enrolled in at UCP

1 ☐ 2 ☐ 3 ☐ 4 or more ☐

How did you hear about UCP?

Family & Friends ☐ Doctor's Referral ☐ UCP Employees ☐ Internet & Social Media ☐ Other ☐

Age Group

0 – 3 ☐ 3 – 12 ☐ 12 – 21 ☐ 21 – 56 ☐ 56 & above ☐

Gender

Male ☐ Female ☐

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 ☐

Two or more Races ☐ 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 ☐

City and ZIP Code:

City: _____ Zip Code: _____

DATE: _____

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CONSENT TO USE INSURANCE

Child's Name: _____ Date of Birth:_____

Private Pay Options

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

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

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

If Yes, Name of Support Coordinator: _____

Phone Number: _____ Email: _____@azdes.gov

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 children who are not DDD eligible. 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.

_____ _____

Name of Parent/Responsible Party *Relationship to Child*

_____ _____

Signature of Parent/Responsible Party *Date*

You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org.

CONSENT TO DISCLOSE AND RECEIVE PROTECTED HEALTH INFORMATION

_____ _____

Child's Full Name Date of Birth

Protected Health Information Authorized to Disclose and 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

_____
Address in Full

_____
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*

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844

PLEASE SEND RECORDS TO UCP OF CENTRAL ARIZONA:

CONSENT TO SHARE\ RECEIVE RECORDS AND INFORMATION WITH PERSON OR AGENCY

_____ _____

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 / Documents ☐

Therapy Progress Reports ☐ Home Programming/Coaching/Strategies ☐

Other (specify): _____

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

receive information as identified above (in writing and/or conversation) to/from the following person/agency:

Person or Agency

_____

Name of Person or Agency

_____

Address in Full

_____

Phone Fax

Sharing of Records and Information

I have read and understand the conditions of this consent. I understand I have agreed to UCP of Central Arizona to send/receive 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*

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, 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*

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.184

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

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844

UCP THERAPY ATTENDANCE POLICY (FOR PARENT/GUARDIAN RECORDS)

UCP of Central Arizona is dedicated to providing high quality therapy services. Your scheduled appointment time is important to us so we may maximize the level of success with your child's plan of care. Attending appointments consistently is required in order to remain in a preferred ongoing time slot.

Cancelling Therapy Appointments

24-hour notice to cancel therapy sessions is required. Options for rescheduling the appointment will be offered when you notify UCP of the cancellation. If you must cancel, or need to change an appointment time, please contact the phone numbers below:

Laura Dozer Center:
Call: (602) 313-8830
Text: (928) 985-0643

UCP Downtown:
Call: (602) 313-8999
Text: (760) 582-5163

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, vomiting, or diarrhea in the 24 hours prior to the appointment, 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 the need to cancel 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.

LATE CANCEL: A late cancellation is defined as notifying UCP of Central Arizona to cancel a therapy session with less than 24-hour notice. Please work with clinic administration to reschedule the appointment. Late cancellations due to emergency situations or illness will be excused, but must not be excessive.

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, but arriving 15 minutes or later to a therapy session may result in a late cancellation and the need to reschedule.

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.

UCP THERAPY 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 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*

The UCP Team is glad you are back for another year! You can drop this form off at the front desk, fax to 602.944.1658 or email therapyreferrals@ucpofcentralaz.org. For questions, 602.682.1844

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, social media, 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, social media etc.

OR

____ NO PERMISSION GRANTED

Authorization and Signature

I certify with my signature below that I authorize the above initialed purposes for use of media involving my child. If I have elected "No permission granted," my child will not be involved in media for UCP.

_____ _____

Parent/Guardian Signature *Date*

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