UCP of Central Florida

Out-Patient Therapy

Dear Parent/Guardian,

Thank you for your interest in the UCP out-patient therapy program. The next step in the enrollment process is the completion of this enclosed packet and submission of other documents. It is important that you complete each form in this packet as much as possible. Additionally, please use the attached checklist to gather the needed documents.

Once you complete and return all the documents, your child will be scheduled for an evaluation with one of our therapists. If you have any questions on the process of documents needed please contact the Family Services Case Manager at your campus.

We look forward to helping your child reach their full potential!

Contact the Family Service Case Manager at your child's campus at 407-852-3300:

UCP East Orange/Bailes Campus - x1004

UCP Holloway/Downtwon Orlando Campus - x7638

UCP Osceola Campus - x6007

UCP Pine Hills Campus - x4005

UCP Seminole Campus - x2004

UCP Transitional Learning Academy - x8356

UCP West Orange Campus - x5002

Thank you again for considering UCP of Central Florida!

Dr. Ilene Wilkins, President/CEO

UCP of Central Florida

Out-Patient Therapy

Thank you for considering UCP as your child's therapy provider! Please fill out each page of the application packet as thoroughly as possible as well as the below additional materials. Use the checklist to make sure you have included all the needed materials:

- ❑ Intake Packet
- ❑ Medical History
- ❑ Therapy Financial Policy Information
- ❑ Photo Release Form
- ❑ Release of Information Form
- ❑ Copy of a Prescription/Referral from your child's primary physician with Diagnosis (DX) code and Doctors' signature (see attached examples)
- ❑ Discharge statement from previous provider whether treatments were provided or not
- ❑ Copy of previous therapy evaluations from past 12 months
- ❑ Copy of insurance card (front and back)
- ❑ Copy of Individual Family Support Plan (from Early Steps) or Individual Education Plan (if applicable)

UCP currently accepts the following insurances:

- ATA
- AETNA
- Amerigroup
- BEECH Street
- Blue Cross/Blue Shield
- Children's Medical Services (CMS)
- Healthease
- Humana
- Prestige
- Optum
- Principal Financial
- Staywell
- Sunshine State
- Tricare Standard (not Military)
- Wellcare

If you do not see your insurance listed – please ask!

UCP of Central Florida

Application Form

Child's Legal Name:

_____ _____ _____ _____
First *MI* *Last* *Generation (i.e.: Jr., II)*

_____ _____ _____ _____
Date of Birth *Birth Place* *Social Security Number* *Student Number*

Gender: M F (*Circle one*) **Ethnicity:** ❑ Hispanic/Latino ❑ Non Hispanic/Non Latino

Race: ❑ White ❑ Asian ❑ Black or African American

❑ American Indian/Alaska Native ❑ Native Hawaiian or other Pacific Islanders

Home Language: Is a language other than English spoken at home?

❑ Yes ❑ No What Language? _____

Dominant Language: Does the student most frequently speak a language other than English?

❑ Yes ❑ No What Language? _____

Native Language: Did the student have a first language other than English?

❑ Yes ❑ No What Language? _____

Do you need communication sent home in a language other than English?

❑ Yes ❑ No If yes, check all that apply: ❑ Spanish ❑ French ❑ Portuguese
❑ Haitian Creole ❑ Vietnamese

Student lives with:

❑ Both parents ❑ Mother only ❑ Father only ❑ Parent and step parent
❑ Legal guardian ❑ Foster Parent ❑ Other:_____

Residential Address:

_____
Street Address

_____ _____ _____ _____
City *State* *Zip* *County*

Mailing Address: ❑ Check if same as residential

_____
Street Address

_____ _____ _____ _____
City *State* *Zip* *County*

UCP of Central Florida

Application Form

Other School Age Children Living at Home:

Child's Name (First and Last) *Relation to Students* *School* *Grade*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Has child been identified as exceptional education? N Y (*Circle one*)

Does child have a *current* IEP, 504 or IFSP? N Y (*Circle one*) IEP / 504 / IFSP (*Circle one*)

Has child ever received a McKay Scholarship? N Y *(Circle One)*

Name of school currently attending: _____ Grade: _____

Address of school: _____ County: _____

Currently under Physician's Care? N Y (*Circle one*)

Physician Information:

_____ _____ _____

Primary Doctor's Name *Address* *Phone*

_____ _____ _____

Primary Dentist's Name *Address* *Phone*

Preferred Hospital: _____

Funding Information *(Check all that apply)*

❑ Medicaid HMO ❑ Medicaid ❑ Kid Care ❑ 4C ❑ Early Steps ❑ Early Head Start ❑ Commercial Insurance

❑ Private Pay ❑ Other:_____

Insurance Information If Commercial Insurance, please complete the following.

_____ _____

Policy Holder's Name *Name of Insurance*

_____ _____

Policy # *Group #*

UCP of Central Florida

Application Form

Parent/Guardian #1 Information: **Custody:** (*Circle One*) Y N **OK to pick up:** (*Circle One)* Y N

_____ _____ _____

First *MI* *Last*

_____ _____ _____ _____

Street Address *City* *State* *Zip*

_____ _____ _____

Home Phone *Cell Phone* *E-mail Address*

_____ _____ _____

Date of Birth *Relationship* Legal Documentation (Ex: custody, restraining order, etc.)

If there is no Legal Alert: Enter "N/A" Please provide supporting documentation

837.06 False official statements. - Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083

Falsification of information will forfeit student's athletic and extracurricular activity for one (1) calendar year from the date of discovery of the violation.

Best time to call: ❑Morning ❑Afternoon ❑Evening

Marital Status: ❑Divorced ❑Separated ❑Married ❑Single ❑Widowed

Employment Status: ❑Active Military ❑Full Time ❑Part Time ❑Retired ❑Self-Employed
❑ In School/Training ❑ Not Working

Parent Family Income: ❑Below $10,000 ❑$10,000-$14,999 ❑$15,000-$19,999 ❑$20,000-$29,999
❑$30,000-$49,999 ❑$50,000-$74,999 ❑$75,000-$99,999 ❑$100,000 and above

Parent/Guardian is a: ❑ Parent ❑ Guardian ❑ Guardian Ad Litem ❑ Surrogate Parent ❑Other/Relative

Primary Parent's Employer: _____ Address: _____

Phone: _____ Occupation: _____

Parent/Guardian #2 Information: **Custody:** (*Circle One*) Y N **OK to pick up:** (*Circle One)* Y N

_____ _____ _____

First *MI* *Last*

_____ _____ _____ _____

Street Address *City* *State* *Zip*

_____ _____ _____

Home Phone *Cell Phone* *E-mail Address*

_____ _____ _____

Date of Birth *Relationship* Legal Documentation (Ex: custody, restraining order, etc.)

If there is no Legal Alert: Enter "N/A" Please provide supporting documentation

837.06 False official statements. - Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083

Falsification of information will forfeit student's athletic and extracurricular activity for one (1) calendar year from the date of discovery of the violation.

UCP of Central Florida

Application Form

Parent/Guardian #2 Information Cont.:

Best time to call: ❑Morning ❑Afternoon ❑Evening

Marital Status: ❑Divorced ❑Separated ❑Married ❑Single ❑Widowed

Employment Status: ❑Active Military ❑Full Time ❑Part Time ❑Retired ❑Self-Employed
❑ In School/Training ❑ Not Working

Parent Family Income: ❑Below $10,000 ❑$10,000-$14,999 ❑$15,000-$19,999 ❑$20,000-$29,999
❑$30,000-$49,999 ❑$50,000-$74,999 ❑$75,000-$99,999 ❑$100,000 and above

Parent/Guardian is a: ❑ Parent ❑ Guardian ❑ Guardian Ad Litem ❑ Surrogate Parent ❑Other/Relative

Primary Parent's Employer: _____ Address: _____

Phone: _____ Occupation: _____

How did you hear about UCP of Central Florida?

❑ Physician
Name: _____
Address: _____
_____

❑ Hospital: _____

❑ Early Steps

❑ Children's Medical Services

❑ Head Start

❑ Early Head Start

❑ School: Orange County Public Schools

❑ School: Seminole County Public Schools

❑ School: Osceola Public School System

❑ School: Other: _____

❑ 4C

❑ Parent
Name: _____

❑ UCP Staff Member
Name: _____

❑ Former Student
Name: _____

❑ Website

❑ Internet Search

❑ Facebook

❑ Twitter

❑ YouTube

❑ Advertisement: Magazine

❑ Advertisement: Postcard

❑ Advertisement: Flyer

❑ Advertisement: Newspaper

❑ Other : _____

As the custodial (custody at least 50% of the time) / enrolling parent I verify that the information provided above is true and correct.

Parent/Guardian Signature: _____ Date: _____

Relationship to child: _____

UCP of Central Florida

Medical History

Patient Name: _____

Pregnancy / Delivery

Pregnancy Proceeded ☐ Without Complications
☐ With Complications

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Polyhydramnios
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclampsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other _____

Length of Pregnancy (in weeks)_____ Prenatal care was ☐ Received ☐ Not Received

Delivery Proceeded ☐ Without Complications
☐ With Complications

- ☐ Abruptio Placenta
- ☐ Breech Presentation
- ☐ Low Birth Weight
- ☐ Negative Vacuum
- ☐ Non-progressive/unproductive Labor
- ☐ Occiput Posterior Postion (Face up)
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Transverse Presentation
- ☐ Prolapsed Cord
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Other _____

Delivery was ☐ Vaginal ☐ C-section ☐ Emergency C-section Length of child's hospital stay: _____

Mother's age at time of birth _____ Birth Hospital _____

Needed to be transferred to another hospital ☐ Yes ☐ No

Transfer Hospital _____

Birth Weight _____ Birth Height _____ Apgar 1 min_____ 5 min _____ 10 min _____

Additional Comments _____

Multiple child pregnancies: # of live births: _____ # of still births: _____

Additional details of birth _____

Complications Following Birth

- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Jaundice treated by light therapy &/or blanket
- ☐ Meconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia (Low Platelet count)
- ☐ Ventilator Dependency
- ☐ VP Shunt
- ☐ Other _____

Diagnosed or Suspected Syndromes

_____

_____

Current Medications

_____

_____

_____

_____

Allergies

_____

_____

_____

Current Vitamins, Herbs, Minerals, Homeopathics

_____

_____

Hearing Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Vision Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Current Physicians			
Name	**Specialty**	**Reason**	**Date of last visit**

Diagnostic Tests		
Test	**When**	**Details/Results**
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Surgeries and Procedures		
Type	**Date**	**Results/Details**

Does the child have:

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy (CP)
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Lukomalasia
- ☐ Reflux
- ☐ Scoliosis Degrees? _____
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury (TBI)
- ☐ Tube Feeding
- ☐ Tubes in ears
- ☐ Vagal Nerve Stimulator
- ☐ None

Other Medical Conditions

_____

_____

_____

Orthopedic Conditions

_____

_____

_____

Additional Comments

_____

_____

_____

Developmental History

Is the child able to:	Began at age (in months):
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully Toilet trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling Over	
Self-bathing	
Self dressing	
Sitting alone without support	
Standing unsupported	
Tying shoes	
Walking with support	
Walking unaided	
Zipping/unzipping jacket	

Is your child ☐ Right Handed ☐ Left Handed ☐ Neither

Concerns about handwriting? ☐ Yes ☐ No Describe: _____

How does child get around the house? _____

Favorite Toys / Play Activities _____

Description of Child

☐ Active	☐ Cautious	☐ Distractible	☐ Insecure	☐ Playful	☐ Other:
☐ Affectionate	☐ Curious	☐ Fearful	☐ Motivated	☐ Shy	_____
☐ Aggressive	☐ Demanding	☐ Fearless	☐ Passive	☐ Stubborn	
☐ Calm	☐ Difficult to Comfort	☐ Fussy	☐ Persistent	☐ Withdrawn	

Sensory processing & Regulation (please select all that apply)

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps hands
- ☐ Allows brushing of teeth
- ☐ Bangs on surface, bangs/hits head
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environment
- ☐ Spins things or self
- ☐ Is sensitive to lights,sounds or noise
- ☐ Sleeps a lot
- ☐ Resists touch
- ☐ Walks on toes
- ☐ Lines up toys or objects
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Resists certain movements (e.g. bouncing, swinging, upside down)
- ☐ Has difficulty figuring out how to move body or takes more time with movements
- ☐ Does not tolerate certain textures (e.g. clothing,surfaces,foods)
- ☐ Uses lots of pressure when touching someone or holding object
- ☐ Has difficulty transitioning from one activity to another
- ☐ Has difficulty falling asleep
- ☐ Has difficulty remaining asleep through the night
- ☐ Appears Lethargic/sleepy all the time
- ☐ Has poor sense of body in space, runs into things
- ☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Hyperfocussed (on specific tasks, people, objects, etc.)

Other: please describe_____

Social/Emotional Skills

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Other: please describe _____
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact

Feeding

Describe Any Feeding Problems

_____

Food Likes _____

_____

Food Dislikes _____

_____

Feeding Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating junior food		Using Utensils to Eat	
Eating table food		Holding own bottle/cup	
Drinking from a Cup		Self-feeding	
Drinking from a Sippy Cup			

Breast Feeding

- ☐ # times currently breast fed per day _____ ☐ Weaned from breast feeding at age: _____
- ☐ Was never breast fed

Current Feeding Adaptations

- ☐ Thickened Liquids: Consistency: _____
- ☐ Adapted Utensils Details: _____
- ☐ Adapted seating Details: _____
- ☐ Calorie supplements Details: _____
- ☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus

Areas of Difficulty

- ☐ Chewing ☐ Drooling ☐ Transitioning Between Foods ☐ Jaw shifts/slides/juts
- ☐ Communication Needs ☐ Swallowing ☐ Understanding Words

Speech Language

Communication Skills		
Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words _____

Augmentative Communication Device _____

Primary Communication ☐ Verbal ☐ Non-Verbal ☐ None

Methods of communication used:

☐ Vocalizations ☐ 2 word Phrases ☐ Facial Expressions ☐ Manual Sign Language ☐ Pointing
☐ Single Words ☐ Complete Sentences ☐ Body Language ☐ Gestures ☐ Eye Gaze

Please describe current speech concerns: _____

_____

_____

_____

Home Environment

Child lives with: (Please select all that apply)

☐ Birth mother ☐ Step-mother ☐ Siblings
☐ Birth father ☐ Step-father Please list siblings ages: _____
☐ Adoptive mother ☐ Grandmother ☐ other relative
☐ Adoptive father ☐ Grandfather Please specify: _____
☐ Legal guardian
Please specify: _____

Additional Comments: _____

_____

_____

Adoption

Age at adoption: _____

Additional Details: _____

Type of Home

☐ Single Level
☐ 2 Level
☐ Ground Floor Apartment
☐ Upper Level Apartment
☐ Assisted Living Facility
☐ Skilled Nursing Facility
☐ Group Home
☐ Other _____

Accessibility

Stairs to get into home: _____ Handrail? ☐ Right ☐ Left ☐ None

Ramp to get into home? ☐ Yes ☐ No

Stairs in home: _____ Handrail? ☐ Right ☐ Left ☐ None

☐ Bathroom on Main Level ☐ Bedroom on Main Level
☐ Bathroom on Upper Level ☐ Bedroom on Upper Level

Additional Comments: _____

_____

_____

Equipment presently used (Please select all that apply)

Equipment:	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc)

Describe any community groups or sports activities the child is involved in

Grade in School _____ Name of School _____

Does your child have an IFSP? ☐ Yes ☐ No

Does your child have an IEP from school? ☐ Yes ☐ No

Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

Therapy Services	Type	Status	How Often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional Comments: _____

Authorization for Release of Information

UCP of Central Florida

I, _____ hereby authorize UCP of Central Florida to request information on this child as indicated below.

Name of Child: _____ **Child's Date of Birth:** _____

Agency:
(Check all that apply)

- ❑ 4C/Early Head Start
- ❑ Child Find (FDLRS)
- ❑ Children's Medical Services
- ❑ County School District: _____
- ❑ County Health Dept.: _____
- ❑ Department of Children and Families
- ❑ Division of Blind Services
- ❑ Easter Seals
- ❑ Early Steps/Part C
- ❑ Pediatrician: _____
- ❑ SSI
- ❑ United Cerebral Palsy of_____
- ❑ Other: _____

Types of information that may be shared:
(Check all that apply)

- ❑ Psychological Testing
- ❑ Social/Developmental History
- ❑ Speech/Language and Hearing Reports
- ❑ Vision/Hearing/Screening Results
- ❑ Occupational/Physical Therapy Records
- ❑ Developmental Assessment Reports
  - ❑ IFSP or ❑ IEP
- ❑ Medical Information and Reports Including:
  - ❑ Medical Records
  - ❑ Immunizations
  - ❑ Physical Examinations Reports
  - ❑ Laboratory Reports
  - ❑ HIV Test Results
  - ❑ Other List: _____
- ❑ Other: _____

I am aware that the information shared will be strictly confidential and cannot be released to anyone else without my written consent. I am aware that I may deny consent to any of the agencies listed above and that I may withdraw my consent at any time by notifying UCP of Central Florida in writing.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

The execution of this form does not authorize the release of information other than that specifically described above. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify.

Example of a Prescription For Therapy Services

UCP of Central Florida

The following elements, at a minimum, should be included on the child's prescription/referral in order for services to be provided.

Child Name:_____ **DOB**: _____

Evaluate and Treat for: _____
(Occupational therapy, speech therapy, or physical therapy)

Diagnosis (DX) Code: _____
(for example - 315.35; 315.32, etc.)

Diagnosis (written): _____
(for example - Childhood Fluency Disorder, Receptive-Expressive Lang. Disorder; etc.)

Doctor's Signature:_____ **Date**: _____

Photo, Video and Internet Release Form

UCP of Central Florida

CONSENT, WAIVER AND RELEASE

For and in consideration of benefits to be derived from the furtherance of the educational programs of UCP of Central Florida, (I) (We), personally and on behalf of _____ the undersigned parent(s) or legal guardians of_____, a student/client entered in the UCP of Central Florida school or therapy system, do hereby consent, authorize and grant permission to UCP of Central Florida, its agents, employees or duly authorized representatives to take photographs, motion pictures or video tapes of said student/client, and do further consent to the publication, circulation and dissemination of said photographs, motion pictures or video tapes or any duplication or facsimile thereof for any purposes it may deem proper, including but not limited to use on the internet. In granting such permission, (I) (We) hereby relinquish and give to UCP of Central Florida, all right, title and interest (I) (We) may have in the pictures, negatives, reproductions or copies, and further waive any and all right to approve the use of such photographs, motion pictures or video footage and further do waive any right to compensation for the publication or other use of said photographs, motion pictures or video footage and do release UCP of Central Florida, its agents, licensees, representatives and assigns from any and all claims of any nature whatsoever arising from their use during the 2015-16 academic and summer school year.

_____ _____

Signature Date

_____

Permanent Address (Number/Street, City, State, Zip Code)

_____ _____

Relationship to Student Email Address

_____ _____

Phone Cell Phone

UCP Campus: _____

Insurance Authorization, Assignment of Benefits and Consent of Therapy Services

UCP of Central Florida

I hereby authorize UCP of Central Florida to furnish all information to insurance carriers and/or Medicaid concerning (Patient's Name) _____, diagnosis and or therapy services. I hereby assign UCP of Central Florida (provider) all payments for therapy and related services rendered to my departments.

I understand that I am responsible for any amount to covered by insurance: this includes any course of treatment that is not a covered benefit. _____ (initials)

I understand that I am responsible for notifying UCP of Central Florida of any personal status changes. _____ (initials)

I understand that I am responsible for notifying UCP of Central Florida of any changes in my insurance coverage. If I am delinquent in updating this information and changes are denied, I understand that I am responsible for these changes. _____ (initials)

I understand that I may be charged an interest rate per month on any unpaid balance and that I am responsible for any costs incurred in collection of said balance should that become necessary. _____ (initials)

Authorization:

I am authorizing my insurance to be utilized throughout the entire calendar year for the following therapy services (please check all that apply):

❑ Occupational therapy evaluation
❑ Occupational therapy treatment
❑ Physical therapy evaluation
❑ Physical therapy treatment
❑ Speech therapy evaluation
❑ Speech therapy treatment
❑ Other _____

I am authorizing my insurance to be utilized only for camp days and summer therapy services (please check all that apply):

❑ Occupational therapy evaluation
❑ Occupational therapy treatment
❑ Physical therapy evaluation
❑ Physical therapy treatment
❑ Speech therapy evaluation
❑ Speech therapy treatment
❑ Other _____

My signature below indicates I understand and accept this policy.

_____	_____	_____
Signature of Legal Guardian/Parent	Printed Name	Date

Insurance Authorization, Assignment of Benefits and Consent of Therapy Services

Consent to release and obtain medical information relating to therapy services and health care operations.

I, _____ (name of client representative) do hereby consent to UCP of Central Florida and any physicians, agencies, schools, health care providers or authorized agents examining or treating named child/client to use or disclose protected health information for therapy services, and payment for health care operations.
Client's health care information will not be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Informed Consent

I hereby give my permission to the staff of UCP of Central Florida to carry out all necessary diagnostic, assessment, and treatment activities which will address the needs of client named above.

_____	_____	_____
Signature	Relationship	Date

I acknowledge that I have read a copy of UCP of Central Florida's "Notice of Privacy Practices." I have read and understand the above and agree to comply.

_____	_____	_____
Signature	Relationship	Date

A copy of this Assignment shall be considered as effective as the original.

Therapy Financial Policy

Child's Name: _____ **Campus:** _____

Thank you for Choosing UCP of Central Florida
Your financial responsibility obligates you to ensure full payment is received for your total services. Therefore, all clients will be required to establish a financial arrangement for payment of their account. All clients must complete and sign the entire enrollment packet prior to receiving services.

Review Your "Schedule of Benefits"
We urge you to review your insurance policy's "Schedule of Benefits". It will help you understand the agreement you have with your insurance company. You should contact your insurance company with any specific questions related to your policy regarding physical, occupational and/or speech language therapy benefits. You should accurately verify and understand your policy's deductible, co-payment, co-insurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to therapy services. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information you receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your charges at the time of service.

Insurance Information
You are required to provide us with complete and accurate information about your policy. We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay and co-insurance as determined by your contract with your insurance company. You are responsible for any amount for any service(s) not covered by your insurer as written in the patient responsibility disclosure.

Changes in Coverage
It is your responsibility to inform us of any and all changes of insurance coverage during the course of therapy service. Failure to do so may result in denial of coverage by your insurance company thus terminating coverage of therapy services and placing financial responsibility on the client.

In-Network
You are responsible for meeting the in-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and/or coinsurance as specified in your "Schedule of Benefits". UCP of Central Florida has agreed with your insurance company to accept the preferred provider maximum allowed charges as full payment for the services rendered. There will be no balance billing for covered services. You are responsible to pay for any services that are received, but not covered under your policy. Co-pays, co-insurance and deductibles are due prior to the time of service.

Out-of-Network
An out-of-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. Some health plans, like HMOs, do not reimburse out-of-network providers at all, which means that as the patient, you would be responsible for the full amount charged by UCP of Central Florida. Other health plans offer coverage for out-of-network providers, but your patient responsibility would be higher than it would be if you were seeing an in-network provider.

Benefit and coverage rules and policies differ among insurers and even between different plans of the same insurer. If you go to an out-of-network provider, your insurance company may only pay a percentage of the rates they determine are usual, customary, and reasonable (UCR) rates. You will be responsible for the amount of charges over the insurer's UCR plus your usual deductible and co- payment.

NON-INSURANCE-FEE-FOR-SERVICE
Fee for service is exclusively a non-insurance financial arrangement. The fee-for-service arrangement is exclusively separate from the in- network and out-of-network scenarios. Fee-for-service receipts cannot be submitted to insurance for reimbursement. UCP offers a discounted prompt pay rate of $45 a session if paid at time of service.

Medicaid
UCP of Central Florida is a Medicaid-approved provider of physical, occupational and/or speech-language therapy. All Medicaid policy holders need to have a physician's referral or prescription prior to starting as a therapy client at UCP of Central Florida. Medicaid reimburses one initial evaluation per recipient, per provider type and one re-evaluation per recipient every six months from the date of receipt of the signed plan of care from your physician, per provider type. An exception is that the first re-evaluation may be done at four months to allow time to obtain authorization to ensure continuum of services.

Primary Insurance
If you have primary insurance you must present it at your initial intake visit or immediately upon enrollment in a primary provider. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

Minors
A parent or legal guardian must accompany the minor client at the time of the initial visit. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information for both parents. The parent or legal guardian that accompanies the minor client to the clinic will have full responsibility for the payment should any dispute arise.

Therapy Financial Policy

Billing Statements
As a courtesy, UCP of Central Florida will submit claims to your health insurance company after each visit, and we will apply payments received to all in-network accounts. If needed, we will re-submit these claims to in-network providers to ensure payment of your benefit for covered services. In the event that repeated submission of claims does not satisfy your bill for the services rendered you will be responsible for the full payment of your bill. Any outstanding bills will be mailed out monthly.

Disputes
Our Financial Policy is designed to promote due diligence and a proactive, rather than reactive, strategy . With your participation, this policy will minimize and potentially eliminate errors, miscommunication and bad information with regard to your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to, deductible, co-insurance, co-payments, covered service, pre-authorization and usual and customary charges.

Payment
We accept Check, Money Order, VISA, American Express and MasterCard. There will be a $35 service charge for all returned checks. Action will be taken if any checks are uncollectable –Florida Statute 65.065 If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, all outstanding charges will be due in full. In the event of default on your account, your account will be turned over to a collection agency. You will be responsible for the unpaid balance any collection fees and an additional finance charge based on your unpaid balance could be assessed.

Attendance Policy
When canceling, you must call at least 2 hours in advance of your scheduled appointment. We reserve a special time frame on our schedule for your appointment, and would appreciate advance notice so that another client could schedule during that valuable time. If you fail to call 2 hours in advance, you will be assessed a cancellation fee of $35. If you "no-show" an appointment you will be assessed a $35 no-show fee.

Confidentiality Policy
UCP of Central Florida adheres to the following confidential policy:

1. All employees, contractors and UCP associates are expected to maintain confidentiality of client's records in accordance with the agency's policies. Client records or information related to the client may be disclosed in only the following circumstances:
   a.) Substantiated abuse or suspected abuse b.) Medical emergency
   c.) A court order (a written authorization will be requested in this case) d.) Written authorization from the client/parent/guardian

2. A client/parent/guardian has the right to see his/her records (with the exception of psychiatric or psychotherapy notes). These records are defined as those composed by UCP of Central Florida and do not include access to records, which have been forwarded to us by any other provider(s). Any client/parent/guardian who believes they have not been given access to appropriate records may file a complaint in the manner outlined in the "Grievance Procedure for Clients/Parents/Guardians" section of the parent handbook.

Uncovered Services
Throughout the course of your therapy services, you may need equipment devices, supplies and materials recommended by your physician and/or therapist. UCP of Central Florida will not submit claims for equipment devices, supplies and materials to your insurance company.

Payments Due at the Time of Service
1. Co-pays and co-insurance are required by your insurance policy are due at the time of service. For all in-clinic therapy services co-pays are due to be paid one week in advance.
2. If your deductible has not been met, UCP of Central Florida requires full payment at the time of service is provided towards your policy's deductible.
3. UCP of Central Florida requires full payment for services rendered for clients who have an out-of-network insurance policy.
4. If you are a non-insurance-fee-for-service client, full payment must be received for the services rendered at the time of service.
5. Cancellation or no-show fees ($35) are due at the time of your next scheduled session.
6. Therapy materials, products and supplies.

I acknowledge that I have read a copy of UCP of Central Florida's "Therapy Financial Policy". I have read and understand the above and agree to comply.

Signature	Relationship	Date
Signature	UCP Representative	Date