



A program of UCP Huntsville  
2075 MAX LUTHER DRIVE, HUNTSVILLE, AL 35810  
PHONE: (256) 852-5600 • FAX (256) 852-6722

**Thank you for giving us the opportunity to provide services to your family!** Here is a breakdown of the documents contained in this envelope:

1. Outpatient Application/Intake Form (6 pages)-Please fill this out completely to the best of your knowledge, and be sure to **sign** all signature lines **with a black "X" to the left**, even if there is no applicable information. On the Records Release Authorization page, at a minimum, please write your child's pediatrician/family doctor on this form.
2. Acknowledgement of Receipt of Patient Privacy Notice (Pink)-this is our acknowledgement that you have received the packet explaining the ways we protect your PHI (personal health information). **Please sign and bring to your child's 1<sup>st</sup> appointment.**
3. Patient Privacy Notice-the packet mentioned above. **This is yours to keep.**
4. Therapy Charge Listing-this is a listing of our charges for services. Your insurance may cover your visits in total or in part, but these are the charges for each visit. Some insurances have deductibles to meet on a yearly basis. If you have any specific questions, we pull your insurance eligibility as a courtesy. You may contact Kim McCain, Billing Coordinator at 852-5600 ext. 103 with any insurance questions. Our office accepts credit cards (MasterCard and Visa), checks, or cash.
5. UCP Services- this page lists all of the additional services we offer, and is yours to keep. Be sure to visit our website [www.ucphuntsville.org](http://www.ucphuntsville.org) or on Facebook at [www.facebook.com/ChildrensTherapyServices](http://www.facebook.com/ChildrensTherapyServices) for more information about services and activities.
6. Photo Release-this form allows us to use your child's photograph for various purposes, including fundraising events, on our website, or for public awareness of our programs at resource fairs or other events. Signing this form is voluntary, and you can revoke your permission at any time.

Please note: **First time appointments for new clients will only be rescheduled one time if missed or cancelled less than 24 hours before the appointment time.**

In order to achieve the most benefit from therapy at UCP, it is **important that your child attend regular appointments as scheduled.** If you are running late, please call us to see if we are able to work you in. **Arriving more than 10 minutes past your appointment time without notice may result in the appointment being rescheduled.**

If it is necessary to cancel your child's scheduled appointment, we require you call at least 24 hours in advance. Appointments with our therapists are in high demand, and your early cancellation will allow another child the opportunity to be seen. **Repeated late arrival times, cancellations less than 24 hours, no shows, and excessive absences may result in a \$25 charge not billable to insurance, loss of standing appointment times, and/or dismissal from UCP's Outpatient Therapy program.** We realize that your reason for cancelling may be unavoidable and we will use our discretion in enforcing penalties.

Thank you again for allowing us the opportunity to work with your family. If you have any questions, please do not hesitate to call me at (256) 852-5600 ext. 100.

Jayne Beshirs, Outpatient Coordinator

# UCP Outpatient Therapy Intake Form

Today's Date \_\_\_\_\_

Client's Name \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street address

City

State

Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail address (please print legibly!) \_\_\_\_\_

Client's Date Of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Client's SSN \_\_\_\_\_

Diagnosis \_\_\_\_\_

Father's Name (if client is a minor) \_\_\_\_\_ Father's Age \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name (if client is a minor) \_\_\_\_\_ Mother's Age \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Client Resides With \_\_\_\_\_

Emergency \_\_\_\_\_

Contact \_\_\_\_\_

Name

Phone

Relationship to Client

Client's Physician \_\_\_\_\_

Please list other agencies, clinics, hospitals, etc. who have served client for therapy, evaluation, consultation, or treatment (ex: Children's Rehabilitation Services, Vocational Rehabilitation, etc.): \_\_\_\_\_

Is the client coming in as the result of an accident or injury?  Yes  No Date of accident: \_\_\_\_\_

Type of accident (car, 3-wheeler, etc.): \_\_\_\_\_ State that accident occurred in: \_\_\_\_\_

Please list the members of household and their relationship to the client.

I hereby give permission for the evaluation and assessment of above client to be performed by qualified professionals as indicated.

I hereby authorize UCP to file insurance and receive payment for services rendered. I am financially responsible for deductibles and other charges accrued that insurance does not cover, at time of service, for above-mentioned client.

X

\_\_\_\_\_  
Client / Parent / Guardian Signature

\_\_\_\_\_  
Date

Would you like to find out more information regarding financial assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this client have a long-term disability? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, you may qualify for financial assistance to cover co-pays, deductibles and/or other accrued charges.

**Medical Insurance/Medicaid Information and Authorization**

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Tertiary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_\_ Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_  
Street Address/P.O. Box City State Zip

I hereby authorize United Cerebral Palsy to release any and all information concerning evaluation, assessment or services to the above insurance companies. I understand that I am financially responsible for charges not covered by insurance. By my signature below, I authorize payment of medical benefits to United Cerebral Palsy for therapy services rendered.

**X** \_\_\_\_\_  
Client / Parent / Guardian Signature Date

**Additional Medical Information**

Were there any prenatal and/or birth problems? If so, please describe: \_\_\_\_\_

Please list date(s) and reason(s) for all hospitalizations and/or surgeries \_\_\_\_\_

Other specialists involved in client's care (please include phone numbers) \_\_\_\_\_

List any known allergies \_\_\_\_\_

Date of last tetanus antitoxin \_\_\_\_\_ Booster \_\_\_\_\_

Contagious diseases, major illnesses, accidents or surgery \_\_\_\_\_

Please list any other pertinent information \_\_\_\_\_

Please list current medication(s) and dosage \_\_\_\_\_

**Client's Emergency Medical Treatment Authorization**

I hereby give permission for provisions of emergency medical treatment for the above-named client as follows:

1. Staff members of United Cerebral Palsy and Tennessee Valley may arrange for transporting the above-named client to the emergency room by calling 911 and following emergency procedures as outlined by 911 personnel.
2. Records pertinent to emergency treatment may be released to hospital personnel.
3. Physicians and hospital personnel have permission to provide emergency medical treatment to the above-named client.
4. **Emergency Care:** UCP has my permission to obtain emergency care at the client's / parent's / caregiver's expense in the event of sickness or accident. I give permission for the client to be transported to the doctor's office or local hospital by ambulance or private car at the expense of my family. The Center's nurse or appropriate staff will determine need for emergency care. I release UCP and its staff of all responsibility for any accident that might occur during participation in a program or during transportation to or from the Center or other Center Activities.

X \_\_\_\_\_  
Client / Parent / Guardian Signature Date

**Authorization for Others to Bring My Child to Appointments**

The following person(s) are hereby authorized to escort my child to and from the UCP Center (i.e. grandparents, other relatives, nanny, etc.). I also authorize the person(s) listed below to receive treatment information about my child at the time they bring or pick-up my child from the appointment:

Name	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

X \_\_\_\_\_  
Client / Parent / Guardian Signature Date



2075 Max Luther Drive  
Huntsville, AL 35810  
CENTER: 256-852-5600  
ADMIN: 256-859-4900  
FAX: 256-852-6722  
www.ucphuntsville.org

### Records Release Authorization

Client's Name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State and Zip

I give my permission to United Cerebral Palsy of Huntsville and Tennessee Valley, Inc., (UCP) to release **and/or** receive information from any individual or agency listed below about the above client's evaluation, assessment or treatment through UCP. I know my permission is voluntary and can be revoked at any time in writing. Copies of this release form will be considered as an original. This signed release form will be effective for one year from date of signature below.

The individual(s) or agency(ies) that are allowed to release/receive information:

1. \_\_\_\_\_  
Name Phone
2. \_\_\_\_\_  
Name Phone
3. \_\_\_\_\_  
Name Phone
4. \_\_\_\_\_  
Name Phone
5. \_\_\_\_\_  
Name Phone
6. \_\_\_\_\_  
Name Phone

Client/Parent/Guardian Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

## OUTPATIENT POLICY

United Cerebral Palsy Center of Huntsville and Tennessee Valley (UCP) Outpatient Program requires compliance with the following statements:

1. I agree to the evaluation and ongoing assessment of myself or my minor child in the areas of physical and/or speech and language development with the understanding that such evaluation and assessment will be conducted by personnel trained to utilize appropriate methods and procedures and will be based on informed clinical opinion and/or formal testing.
2. Prescriptions, EPSDT, and other medically necessary information must be submitted prior to enrollment into the program. I agree to assist the UCP staff in annually updating medical referrals and health status as needed. I further agree to request pertinent records as specifically authorized by my signature on appropriate release forms.
3. Parent / caregiver participation is required for maximum benefit from therapy. Homework will be assigned and it will be the responsibility of the parent / caregiver to assist with that effort.
4. **Attendance:** Parent/guardian is expected to give 24 hour notice for any cancellation of appointments. Advance notification is required in cases of scheduled absences (i.e. family vacations, conflicting medical appointments, surgery, etc.). Tardiness is defined as bringing a child 10 or more minutes late of appointment time. If a client arrives 10 or more minutes late, it will be at the therapist's discretion to proceed with the therapy session or reschedule the appointment (which will count as a missed appointment). Clients who are tardy, but are seen for therapy, will not receive all scheduled therapy. Missed appointments are considered "no shows" for those that have been confirmed, or attempted to be confirmed using the contact information on file, in which the client family does not arrive for the scheduled appointment and gives no notice to the UCP Center. A late cancellation is defined as less than 24 hour notice of cancellation.

Penalties for absences, tardiness, missed appointments, or late cancellations which may be enforced:

1. An overall absence rate (including cancellations made more than 24 hours in advance) of 50% or more over a three month period may result in loss of any standing appointments and/or discharge from UCP's Outpatient Therapy program.
2. Missed ("no show") or late cancellation (less than 24 hour notice) penalties:
  - a. 1<sup>st</sup> missed appointment or late cancellation – no penalty
  - b. 2<sup>nd</sup> missed appointment or late cancellation- \$25 charge and loss of any standing appointments (future appointments will be scheduled one at a time)
  - c. 3<sup>rd</sup> missed appointment or late cancellation – \$25 charge and discharge from UCPs' Outpatient Therapy program with notification to referral source
5. I understand that siblings are welcome in the Center and that the caregiver is responsible for their care. **Siblings are not allowed in the therapy or work areas of the Center, unless authorized by the client's therapist.**
6. I understand that the client is responsible for paying any deductible and / or copays on their insurance coverage. Any payment plan set up with UCP is due upon receipt of services. All questions and concerns about insurance, Medicaid or personal pay plans should be addressed to our insurance billing personnel.
7. I understand that I am responsible for any equipment loaned to my minor child or myself. If equipment is not returned within 6 months from date of loan, I will be directly responsible for any costs incurred to replace the item.

X

\_\_\_\_\_  
Client / Parent / Guardian Signature

\_\_\_\_\_  
Date

## OUTPATIENT POLICY PARENT COPY

United Cerebral Palsy Center of Huntsville and Tennessee Valley (UCP) Outpatient Program requires compliance with the following statements:

8. I agree to the evaluation and ongoing assessment of myself or my minor child in the areas of physical and/or speech and language development with the understanding that such evaluation and assessment will be conducted by personnel trained to utilize appropriate methods and procedures and will be based on informed clinical opinion and/or formal testing.
9. Prescriptions, EPSDT, and other medically necessary information must be submitted prior to enrollment into the program. I agree to assist the UCP staff in annually updating medical referrals and health status as needed. I further agree to request pertinent records as specifically authorized by my signature on appropriate release forms.
10. Parent / caregiver participation is required for maximum benefit from therapy. Homework will be assigned and it will be the responsibility of the parent / caregiver to assist with that effort.
11. **Attendance:** Parent/guardian is expected to give 24 hour notice for any cancellation of appointments. Advance notification is required in cases of scheduled absences (i.e. family vacations, conflicting medical appointments, surgery, etc.). Tardiness is defined as bringing a child 10 or more minutes late of appointment time. If a client arrives 10 or more minutes late, it will be at the therapist's discretion to proceed with the therapy session or reschedule the appointment (which will count as a missed appointment). Clients who are tardy, but are seen for therapy, will not receive all scheduled therapy. Missed appointments are considered "no shows" for those that have been confirmed, or attempted to be confirmed using the contact information on file, in which the client family does not arrive for the scheduled appointment and gives no notice to the UCP Center. A late cancellation is defined as less than 24 hour notice of cancellation.

Penalties for absences, tardiness, missed appointments, or late cancellations which may be enforced:

3. An overall absence rate (including cancellations made more than 24 hours in advance) of 50% or more over a three month period may result in loss of any standing appointments and/or discharge from UCP's Outpatient Therapy program.
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12. I understand that siblings are welcome in the Center and that the caregiver is responsible for their care. **Siblings are not allowed in the therapy or work areas of the Center, unless authorized by the client's therapist.**
13. I understand that the client is responsible for paying any deductible and / or copays on their insurance coverage. Any payment plan set up with UCP is due upon receipt of services. All questions and concerns about insurance, Medicaid or personal pay plans should be addressed to our insurance billing personnel.
14. I understand that I am responsible for any equipment loaned to my minor child or myself. If equipment is not returned within 6 months from date of loan, I will be directly responsible for any costs incurred to replace the item.

## PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

### PLEASE REVIEW IT CAREFULLY

#### USE AND DISCLOSURE OF HEALTH INFORMATION

United Cerebral Palsy of Huntsville and Tennessee Valley, Inc. (UCP) may use your health information for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. UCP has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED.

**To Provide Treatment:** UCP may use your health information to coordinate care within UCP and with others involved in your care, such as your attending physician.

**To Obtain Payment:** UCP may include your health information in documentation used to collect payment from third parties for the care you may receive from UCP. For example, UCP may be required by your health insurer to provide information regarding your health care status so that your insurer will pay benefits for treatment received. UCP may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for treatment and the services we will provide to you.

**To Conduct Health Care Operations:** UCP may use and disclose health care information in order to facilitate the management of UCP. Health care operations include such activities as:

- Quality assessment and improvement activities
- Activities designed to improve health care or reduce health care costs
- Professional review and performance evaluation
- Training programs including those in which students, trainees or practitioners in health care learn under supervision
- Accreditation, certification, licensing or credentialing activities
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs
- Business planning and development including cost management, establishing fees for services, and planning related analyses
- Business management and general administrative activities of UCP

For example, UCP may use your health information to evaluate its staff's performance, combine your health information with other UCP patients in evaluating how to more effectively serve all UCP patients, disclose your health information to UCP staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding an appointment.

**When Legally Required.** UCP will disclose your health information when it is required to do so by any Federal, State or local law.

**When There are Risks to Public Health.** UCP may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.



- Notify an employer about an individual who is a member of the workforce as legally required.

**To Report Abuse, Neglect or Domestic Violence.** UCP is required by law to notify government authorities if UCP believes a patient is the victim of abuse, neglect or domestic violence. UCP will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities.** UCP may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action.

**In Connection with Judicial and Administrative Proceedings.** UCP may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. UCP will make reasonable effort to notify you about the request.

**For Law Enforcement Purposes.** UCP may disclose your health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if UCP has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime.

**In the Event of a Serious Threat to Health or Safety.** UCP may, consistent with applicable laws and ethical standards of conduct, disclose your health information if UCP, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, the Federal regulations authorize UCP to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, and medical suitability determinations.

**For Worker's Compensation.** UCP may release your health information for worker's compensation or similar programs.

## **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than stated above, UCP will not disclose your health information other than with your written authorization. If you or your representative authorizes UCP to use or disclose your health information, you may revoke that authorization in writing at any time.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that UCP maintains and you may ask for any of the following in writing to the HIPAA OFFICER. Requests will be processed within 10 business days from the date of the request:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on UCP's disclosure of your health information to someone who is involved in your care or the payment of your care. However, UCP is not required to approve your request.
- **Right to Receive Confidential Communications.** You have the right to request that UCP communicate with you in a certain way. For example, you may ask that UCP only conduct communications pertaining to your health information with you privately with no other family members present. UCP will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

- **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information, including billing records. If you request a copy of your health information, UCP may charge a reasonable fee for copying and assembling costs associated with your request.
- **Right to Amend Health Care Information.** If you or your representative believes that your health information records are incorrect or incomplete, you may request that UCP amend your records. That request may be made as long as the information is maintained by UCP. UCP may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by UCP, if the records you are requesting are not part of UCP's records or if, in the opinion of UCP, the records containing your health information are accurate and complete.
- **Right to an Accounting of Disclosures.** You or your representative have the right to request an accounting of disclosures of your health information made by UCP for any reason other than for treatment, payment or health operations. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. UCP will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Requests for accounting of disclosures will be handled within 3 business days of receipt.
- **Right to a Paper Copy of This Notice.** You or your representative has a right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. A copy will also be posted at the center. Subsequent copies are available at no charge electronically via email.

### **COMPLAINTS AGAINST UNITED CEREBRAL PALSY OF HUNTSVILLE AND TENNESSEE VALLEY, INC.**

**Right to File a Complaint Against UCP Without Fear of Retaliation.** You or your representative has a right to file a complaint against UCP regarding the handling of protected health information. Complaints should be filed in writing with UCP's HIPAA Compliance Officer or with the DHHS secretary if not resolved directly with UCP.

### **DUTIES OF UCP**

UCP is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. UCP is required to abide by terms of this Notice as may be amended from time to time. UCP reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If UCP changes its Notice, UCP will provide a notice of amended language to you or your appointed representative. A copy of the revised Notice is also available upon request. You or your personal representative has the right to express complaints to UCP and to the Secretary of Health and Human Services if you or your representative believes that your privacy rights have been violated. Any complaints to UCP should be made in writing to UCP's HIPAA Compliance Officer. UCP encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

### **CONTACT PERSON**

UCP's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is UCP's HIPAA Compliance Officer, @ (256) 852-5600.

*The rights described in this document cannot be waived.*

### **EFFECTIVE DATE**

This Notice is effective April 14, 2003.

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE,**

**PLEASE CONTACT UCP's HIPAA Compliance Officer @ 256-852-5600.**



ACKNOWLEDGEMENT OF RECEIPT OF  
PATIENT PRIVACY NOTICE

I acknowledge that I have received on this date \_\_\_\_\_ a copy of UCP's Patient Privacy Notice dated 4/14/03.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Authorized Signature (client, parent or guardian)

\_\_\_\_\_  
Please print the name of the person signing above:

Relationship to client: \_\_\_\_\_

## **Therapy Charges**

### **Speech Therapy**

Evaluation (1 hour)	\$125.00
30 minute session	\$75.00

### **Physical Therapy**

Evaluation (1 hour)	\$125.00
30 minute session	\$80.00

### **Occupational Therapy**

Evaluation (1 hour)	\$125.00
30 minute session	\$80.00

### **UCP Therapy Staff**

#### **Physical Therapist**

Cheryl Ramos, PT, DPT  
Lindsey Lamm, PT, DPT

#### **Occupational Therapists**

Janet Taylor, OTR/L

#### **Speech-Language Pathologists**

Ann Ruble, MEd, CCC-SLP  
Kayla Kinzer, MCD, CCC-SLP

#### **Outpatient Coordinator**

Jayne Beshirs

#### **Billing Coordinator**

Kim McCain



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**RELEASE FORM**

Authorization to Release Protected Health Information by United Cerebral Palsy of Huntsville and Tennessee Valley, Inc. (UCP)

Client (Child) Name: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

I hereby authorize UCP to use and disclose the following protected health information:

- |  |                                   |
|--|-----------------------------------|
| Photographs of client and/or family              | Videotape of client and/or family |
| Client's name                                    | Client's age                      |
| Client's diagnosis                               | Shared personal story             |
| Types and frequency of treatment received at UCP |                                   |

The above information may be used for the following events from the date of signature at the bottom of this release until the expiration date at the bottom of this release:

- Print media, including regional newspapers
- Electronic media, including radio, TV and internet websites
- Special events and promotion thereof
- Community fundraising events for UCP and promotion thereof
- Irish Evening and promotion thereof
- UCP web page
- Information fairs / displays in the UCP Center and off-site
- UCP family newsletter
- Proposals and thank you items for corporate sponsors / donors
- Seasonal parties
- Tour groups

UCP of Huntsville and Tennessee Valley has my permission to use my or my child's photograph, likeness, artwork, profile and/or story in all forms of media and all manners, including publications, web pages, and other promotional materials. I understand the circulation of the materials could be worldwide and that there will be no compensation to me for this use. I waive any right to inspect or approve the finished product, including written copy that may be created in connection therewith.

I understand that I can revoke this authorization in writing at any time. I further understand that UCP cannot deny treatment or services if I refuse to sign this authorization. I understand that, once this information is released, UCP is not responsible for information released by others.

Signature of Parent/Legal Guardian: \_\_\_\_\_

My E-Mail Address: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

## **Other UCP Programs**

### **Early Intervention**

UCP is one of several Early Intervention programs in the area that serves children from ages birth to three with developmental delays or certain diagnosed conditions. Early Intervention provides resource access, family support, and appropriate services.

### **Playgroups**

UCP offers two separate playgroups for UCP clients and children with special needs in the community. Monday Playgroup is for ages 1-3 and is staffed by a PT, OT, SLP, and developmental specialist. We also offer a Preschool Readiness Playgroup on Wednesdays for ages 2 1/2 -4, which is staffed by developmental specialists with consultation from therapists.

### **Parent Support Groups**

Our Parent Educator leads two parent groups on Monday mornings at UCP during the school year.

### **Childcare Provider Training**

CCEP provides free onsite training, consultation, and technical assistance for childcare providers throughout North Alabama. Training topics include, but are not limited to, principles of inclusion and strategies for identifying children at-risk for developmental delays.

### **Family Connections**

Family Connections provides resource and referral; child development and behavioral management training; and opportunities for socialization and mentoring to families who have children with special needs.

### **Respite**

Alabama Respite, a statewide project of UCP, maintains a directory of available respite services in all 67 counties of Alabama. Through the Department of Mental Health, Alabama Respite provides voucher respite services for caregivers of individuals of any age who have an intellectual disability.

H.E.A.R.T.S. Respite is offered in North Alabama for caregivers of children with special needs ages birth-19. The H.E.A.R.T.S. program is funded by the Alabama Department of Child Abuse and Neglect Prevention.

### **Technology Assistance for Special Consumers (T.A.S.C.)**

T.A.S.C.'s mission is to provide individuals with disabilities, their families, and/or advocates, and associated professionals access to assistive technology devices and services to increase independence at home, school, and work. Services include a lending library of specialized technology, Augmentative and Alternative Communication (AAC) evaluations, and onsite/online professional and family training and resources.

For more information about UCP programs and events:

[www.ucphuntsville.org](http://www.ucphuntsville.org) and [www.Facebook.com/UCP.Huntsville](https://www.Facebook.com/UCP.Huntsville)

For information related to the UCP Therapy Center and therapy-related resources:

[www.Facebook.com/ChildrensTherapyServices](https://www.Facebook.com/ChildrensTherapyServices)