



159 Carleton Avenue
Central Islip, New York 11722
Tel: 631-439-4300
Fax: 631-439-4309

33 Terryville Road
Pt. Jefferson Station, NY 11776
Tel: 631-474-5100
Fax: 631-474-5185

250 Marcus Boulevard
Hauppauge, NY 11788
Tel: 631-232-0011, ext. 242
Fax: 631-232-0807

REGISTRATION PACKET INFORMATION SHEET

All information requested must be furnished in order to receive the services requested from the UCP HEALTH CENTER. Please pay special attention to the private insurance information requirements. Medicaid regulations dictate that private insurance and Medicare are billed before we can bill Medicaid. (Please be reminded that any attempt to avoid disclosing insurance coverage is considered to be fraud by Medicaid).

1. Please provide photocopies of the following:

- Medicaid Card
- Medicare Card
- Private insurance card(s) – front and back of card(s)

2. If you have private insurance, please make sure to:

- Complete the Private Insurance Information on page 3
- Sign the Assignment of Benefits Agreement Form on page 4

3. Please provide any prescriptions you have for the following services:

- Audiology Evaluation [If the evaluation is for hearing aids and you have Medicaid coverage, the prescription must state that you are “Medically Cleared for Hearing Aids” and “Ears are Free of Cerumen (wax)”.
- ASSISTIVE TECHNOLOGY Evaluation (that is for new wheelchair evaluation, seating and positioning, augmentative communication, etc.)
- MENTAL HEALTH (Psychological, Neuropsychological, Psychosocial, Counseling, Psychotherapy, Psychiatry Intake by Social Worker)
- PT, OT, Speech evaluations

4. Please provide the following most recent documentation:

- PPD
- Individualized Service Plan (ISP)
- Physical Examination
- PT, OT, Speech Evaluations and progress notes
- Immunizations
- Medications

NOTE: If you have a primary care physician from outside the UCP Suffolk Health center, you can obtain a prescription from him/her and send it to us with your completed packet.

Please return completed packet to: Intake Desk
UCP Suffolk Health Center
159 Carleton Avenue
Central Islip, NY 11722

Tel # 631-439-4320 or FAX #631-439-4329



PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: ____ - ____ - ____
Date of Birth: ____/____/____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _____

(Street) (City/State/Zip)

Home Phone: (____) _____ - _____ E-mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? (examples: appointment reminders, administrative updates and health bulletins) Yes No

Legal Guardian: _____ Relationship to patient _____

Employer Name: _____ Employer Phone Number: (____) _____

Employer Address: _____

(Street) (City/State/Zip)

Primary Care Physician: _____

How did you hear about our Health Center? _____

Do you have a disability? _____ Please describe _____

If yes, onset before age 22: _____ Onset after age 22? _____

Do you have any language/communication barrier? Yes _____ No _____ Explain _____

WHAT SERVICES ARE YOU REQUESTING? _____

Why are you requesting these services? _____

LIVING ARRANGEMENT: _____ Private Residence _____ Institution _____ FamilyCare _____ CR
(Community Residence) _____ ICF-MR _____ IRA _____ Foster Care _____ Other (Specify) _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: ____ - ____ - ____

Relationship to Patient: (please check): () self, () spouse, or () parent Date of Birth: ____/____/____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (____) _____

Employer Address: _____

(Street) (City/State)

Service Coordinator:

Name: _____ Agency: _____

Phone: (____) _____ - _____ Other Information: _____

Who to call for an emergency:

Name: _____ Address: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Relationship: _____

MEDICAID #

SEQUENCE #

MEDICARE #

Note: If a patient is covered by Private Health Insurance, whoever's name the Policy is enrolled under is responsible for payment of all deductibles and that part of the fee not covered by the insurance policy. Please attach 2 completed Insurance Claim Forms with this application for each private health insurance coverage.

The policyholder must sign the Assignment of Benefits Agreement on page 3 of this packet, assigning benefits to UCP. Please note that you will be asked to complete an Assignment of Benefits Form for each private insurance coverage.

Additional INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

Additional INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

Additional INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: ____/____/____ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y__ N__

RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to UCP of Suffolk Health Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____
Patient/Parent/Guardian/Representative Signature

Signature: _____ Date: _____
Policyholder on behalf of Patient, if different than above

ASSIGNMENT OF BENEFITS AGREEMENT

Date: _____

Patient: _____

Policyholder: _____

Employer: _____

Claim Group _____

SS#/ID _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:UCPA of Greater Suffolk Inc., 250 Marcus Blvd.,Hauppauge, NY 11788

Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

UCPA of Greater Suffolk Inc., 250 Marcus Blvd., Hauppauge, NY 11788

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20_____.

Signature of Policyholder _____

Signature of Claimant, if other than Policyholder _____

Signature of Witness _____

Full Time Clinic Sites:

159 Carleton Avenue, Central Islip, NY 11722, (631)439-4300– Fax (631) 439-4319

33 Terryville Road, Pt. Jefferson Station, NY 11776 (631) 474-5100 – Fax (631) 474-5185

FOR YOUR INFORMATION

PATIENT'S RIGHTS (as per NYS Department of Health Article 28 Regulation 751.9) *Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;*

- *Be treated with consideration, respect and dignity including privacy in treatment;*
- *Be informed of the services available at the Center;*
- *Be informed of the provisions for off-hour emergency coverage;*
- *Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;*
- *Receive an itemized copy of your account statement, upon request;*
- *Obtain from your health care practitioner, or the health care practitioner's delegate, complete and current information concerning your diagnosis, treatment and prognosis in terms you can be reasonably expected to understand.*
- *Receive from your physician information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both, the reasonably foreseeable risks involved and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting you or your representative to make a knowledgeable decision;*
- *Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of your action;*
- *Refuse to participate in experimental research;*
- *Express complaints about the care and services provided and to have the Center investigate such complaints. The Center is responsible for providing you or your representative with a written response within 30 days if requested by you indicating the findings of the investigation. The Center is also responsible for notifying you or your representative that if you are not satisfied by the Center's response, you may complain to the NY State Department of Health's Office of Health Systems Management;*
- *Privacy and confidentiality of all information and records pertaining to your treatment;*
- *Approve or refuse the release of disclosure of the contents of your medical record to any health care practitioner and/or health care facility except as required by law of third-party payment contract; and*
- *Access your medical record pursuant to the provision of Section 18 of the Public Health Law and sub-part 50-3 of Title 10.*

PATIENT'S RESPONSIBILITIES

- *Adhere to all health and safety rules and regulations of Federal, State, Local, and Agency for the protection and safety of all;*
- *Arrange and keep appointments with service provider. Give 24 hours notice if an appointment cannot be kept;*
- *Pay fees which have been pre-arranged with the service provider and/or comply with request for information on insurance coverage;*
- *Assist in planning treatment goals;*
- *Follow through with agreed upon goals;*
- *Inform your service provider if you decide not to continue services.*

Do not write below line- for office use only

Check off documentation received:

- PPD
- Individualized Service Plan (ISP)
- Physical Examination
- PT, OT, Speech Evaluations and progress notes
- Immunizations
- Medications