Ucla
Sports Medicine

CAPS Referral and Fee Payment Authorization

UCLA Student-Athlete: _____UCLA ID#:_____-_____-_____

Sport: _____ Please charge to account number 763-203-SA05

Place of Service: UCLA Counseling and Psychological Services
John Wooden Center West
(CAPS Entrance faces the Intramural Field)
Open Monday-Friday from 8 a.m. to 5 p.m.
221 Westwood Plaza
(310) 825-0768

Counseling and Psychological Services (CAPS) for Athletics

The listed student-athlete is hereby authorized for services at your facility. It will be effective for a period determined by your provider and the Director of Sports Medicine. The $15 fee per individual and group therapy visit, $150 for psychiatry intake, and $75 for psychiatry follow up visit (if needed) will be paid for by the UCLA Intercollegiate Athletic Department. Payment will be made via interdepartmental recharge at the end of the month in which service(s) is/are obtained. Please note that if the student-athlete is enrolled in SHIP, the $15 fee per visit will be paid by SHIP. Also note that the **$20 fee for same-day cancellation or missed appointments is the responsibility of the student-athlete and should be billed to their BAR account.**

This authorization letter is required for the initial visit of the current school year and is effective for a period of time to be determined by the provider and will last no longer than one academic year (Fall through summer of the current year). Any services provided outside of CAPS as a result of a referral will require pre-approval by the student-athlete's primary insurance and the Director of Sports Medicine- (310) 794-1547 to provide financial coverage.

If you have any questions, please contact Mark Pocinich at (310) 794-1547 or by e-mail at: mpocinich@athletics.ucla.edu.

Student-Athlete

I understand that my CAPS' co-payment for services will be covered by Athletics for the above listed dates and that I must present this letter at my first session at CAPS.

Are you enrolled in SHIP (Student Health Insurance Plan)? ☐ YES ☐ NO

There is a $20 fee for same day cancellation or missed appointments. Should this occur, you are responsible for this fee and it will be billed to your account.

Please sign and date below indicating that you have read and understand this statement.

Signature of Student-Athlete:_____ Date:_____

Appendix A

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name: _____

UC ID #: _____ Date of Birth: ___/___/_____

Address: _____

City: _____ State: Zip: _____ Phone: _____

I authorize: (Person or facility which has and medical and mental health information)

Name: UCLA Counseling & Psychological Services
Address: John Wooden West, Box 951556
Los Angeles, CA 90095-1556
Phone: 310-825-0768
Fax: 310-206-7365

☐ To release or ☐ to exchange medical information to/with: (Person or facility to receive health information)

Name: Mark Pocinich
Address: 100 JD Morgan Center, Box 951639
Box 951639, Los Angeles, CA 90095
Phone (310) 206-6107
Fax (310) 206-1985

Type of disclosure:

☐ Verbal Information ☐ Copies of records ☐ Letter ☐ Proof of Attendance ☐ Billing Only

Please specify the information you authorize to be released:

☐ Mental health information (Subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.).

☐ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)

☐ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).

☐ HIV/AIDS test results (Health and Safety Code §120980(g)).

Type(s) of information, if not specified above (e.g. Summary Report)_____

_____

Specify date(s) of treatment, time period or condition:_____

_____

Limitations upon disclosure: _____

_____

The purpose of this release is:

☐ At the request of the client/patient/patient representative

☐ Other (state reason) _____

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires on_____.
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____

Client/Patient/Patient Representative Signature

_____ _____

Relationship to Client/Patient (if other than Client/Patient) Date

NOTICE: UCLA-CAPS and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to:

UCLA Counseling and Psychological Services, John Wooden Center West, Campus or mail to: Box 951556, Los Angeles, CA 90095-1556

The revocation will take effect when UCLA-CAPS receives it, except to the extent UCLA-CAPS or others have already relied on it. You are entitled to receive a copy of this Authorization.

You have the right to receive written acknowledgment from a non-medical recipient of the information being released pursuant to this authorization agreeing to abide by the restrictions contained in this release. By signing here, you waive the right to receive such a signed written agreement from the intended recipient:_____Date_____