Provider Application

CONCERNED associates

PERSONAL INFORMATION:

Last Name First M.I. Past/Current Professional name (s) used

Home Address City State Zip Phone

SS# _____ DOB: _____ County/State of Birthplace: _____

Highest Degree: _____ Discipline: _____ Licensed as: _____State: ____
U.S. Citizen? Yes No If no, status of Visa at the present time: _____
Native Language: _____ List Languages Fluent: _____

PRACTICE LOCATION /BILLING INFORMATION:
Sole Provider Group Provider Group/Business Name: _____
Tax I.D #: _____ Group ID? Individual ID?
If a group provider, are you accredited? Yes No JCAHO CARF Other _____
Contact Person: _____ Title: _____ Phone # _____
Primary Office Address:

Street Address City State/Zip

County Phone # Fax # E-mail Address

Mailing/Billing Address (if different from primary office address):

Street Address City State/Zip

County Phone # Fax # E-mail Address

Billing/Accounts Manager: _____ Phone #: _____

PROFESSIONAL LIABILITY INFORMATION:
*Please enclose copy of current carrier.
Current Carrier: _____ Address: _____
Phone: _____ Policy # _____
Previous Carriers: please list carrier for the past 5 years.
Past Carrier: _____ Address: _____
Phone: _____ Policy # _____

PRACTICE INFORMATION
List office hours: Monday through Sunday:
_____
_____

Are you able to schedule clients for an initial appointment within 7 days of their first contact with your practice? Yes No. If not, within how many days? _____
Do you provide 24-hour coverage? Yes No Night/Beeper, Answering Service Number _____
What is your procedure to handle after business hour calls?

Client Population: Please check the age ranges for which you serve.

Adult (19-64) Adult (65 +) Adolescent (13-18 years) Child (6-12) Child (1-5)

Are your office locations wheelchair/handicap accessible? Yes No
Is your office located within one block of public transportation? Yes No

Treatment Modalities/Approaches:

Please indicate modalities you currently employ in your practice:

Individual Couple/Conjoint Group Family EMDR Psychotherapy
Biofeedback Hypnotherapy Solution-Focused Therapy Brief Systemic
Internal Family Systems Cognitive Behavioral/Rational Relation Therapy
Reality Experiential _____ Other:

_____

Clinical Services for Specific Disorders

ADHD/ADD Anxiety Disorders Adjust/Re-Adj.Disorders Mood Disorders
Psychotic Disorders Personality Disorders Psychosomatic/Somatoform Addictions
Trauma/Crisis Terminally Ill Grief/Bereavement Head Injury Patients
Chronic Pain/Illness HIV Positive Patients Sexual Disorders Eating Disorders
Post Traumatic Stress Others Not Listed: _____

Professional Society Memberships And/Or Fellowships

Please names and inclusive dates of memberships:

_____
_____
_____

LICENSURE AND OTHER REGISTRATIONS/CERTIFICATIONS:

*Please enclose copy of licenses/registrations and certifications.

State: ____ License # _____ Title: _____ Expiration Date: _____
State: ____ License # _____ Title: _____ Expiration Date: _____
State: ____ License # _____ Title: _____ Expiration Date: _____
State: ____ License # _____ Title: _____ Expiration Date: _____

Copies of current enclosed.

EDUCATION/EXPERIENCE

*Please enclose vita/resume to provide information on employment experience, education, internship, or equivalent positions in chronological order. Employment history must include all positions held for the last five years. Please provide explanation for any gaps in history.

_____
_____

Previous practice locations and dates:

Practice Name	Address	Dates
Practice Name	Address	Dates
Practice Name	Address	Dates

VOLUNTARY INFORMATION:

Not only do customers often express preferences for therapists of a particular ethnic background or gender, but also employers may wish to determine if our network reflects the ethnic/gender profile of their employees. If you volunteer to provide the following information, it will be held in the strictest confidence. It will be used only when a customer indicates such information is important when selecting a provider or in the aggregate profile of our network.

Gender: Male Female

Ethnic Background _____

DISCLOSURE QUESTIONS:

Please provide a complete, signed and dated explanation on a separate sheet if any of the following questions are answered in the affirmative. Thank you.

Yes No 1. Have you ever been named in any malpractice action? (this would include pending claims or lawsuits, dismissed or dropped claims/lawsuits, settlements and final judgements.)

Yes No 2. Has your professional liability carrier ever cancelled your insurance or refused renewal?

Yes No 3. Has your professional license or registration or certification ever been terminated, suspended, voluntarily relinquished, refused, or not renewed by any licensing or certification board of any health related agency, or is there a review pending?

Yes No 4. Has your membership, participation, clinical privileges or employment ever been denied, terminated, restricted, refused, revoked, or not renewed by any peer review organization, third party payer, medical staff, or any health related agency, or is there a review pending?

Yes No 5. Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, misdemeanor (other than a traffic violation), or other offense involving fraud, misrepresentation, dishonesty or deceit?

Yes No 6. Have you ever been found liable, guilty or responsible for sexual impropriety, misconduct, or sexual harassment?

Yes No 7. Are you currently using illegal drugs?

Yes No 8. Do you have a condition that would affect your ability, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing significant health or safety risk to your clients?

ACKNOWLEDGEMENTS AND ATTESTATION

I wish to participate in ***CONCERNED* associates** Provider Network. I hereby certify that all information in this application is complete, true and accurate. I further understand that information entered into this application which is subsequently found to be false could result in a change of my status as a provider and/or the cancellation of any contract or employment agreement I may have entered into with ***CONCERNED* associates**. If any material changes occur affecting my professional status, I understand it is my obligation to notify ***CONCERNED* associates** and I agree to do so in a timely manner.

Print Name/Credentials:_____

Signature: _____

Date: _____ / _____ / _____

Check List

Copy Of Professional Liability Insurance Cover Sheet Enclosed?
Copy Of Licenses/Registrations And Certifications Enclosed?
Vita/Resume Enclosed?
Diploma Enclosed?
A Complete, Signed And Dated Explanation On A Separate Sheet If Any Of The Disclosure Questions Are Answered In The Affirmative, Enclosed?
Application Is Signed And Dated.