INDIVIDUAL PROVIDER APPLICATION

GENERAL INFORMATION

Last Name **First Name** **Middle** **Degree/License**

Social Security Number **Tax Identification**

Date of Birth:______________________ **Sex:** ___**Male** ___**Female**

Office Location(s) (attach as needed):

Practice Name____

Street **Suite**

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

Mailing or Billing Address (if different):

Street **Suite**

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

Handicap Accessible? Yes No **Public Transportation Accessible? Yes No**

Telephone No:_____________________________ **Ext.**_______

Email: ____
Can we send referrals through email? Yes No

Website:____

Do you have a Psychology Today account? Yes No (not required)

Additional Information:

List languages fluent in other than English___________________________________

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LIABILITY/MALPRACTICE COVERAGE INFORMATION: Please provide copy Liability Insurance Certification

Present Carrier: ____

Policy No.: ________________________ **Expiration Date:**____________________

Coverage Limit: **Per Occurrence:**__________ **Aggregate:**_____________

Are there any claims pending against you? __Yes __No

Do you have any prior judgments or settlements against you? __Yes __No

Has your liability/malpractice coverage ever been denied, cancelled or non-renewed? __Yes __No

Have you ever had your license or certification denied, terminated, restricted, or voluntarily relinquished or have you been subjected to disciplinary action? __Yes __No

Have you ever been suspended from practice or subjected to disciplinary action at a hospital or other health care organization? __Yes __No

Have you ever been subject to discipline proceedings by professional organizations, licensing board, hospital staff or other such entity? __Yes __No

Have you ever been convicted of a felony or other crime? __Yes __No

Do you or have you ever suffered from an illness, physical or psychological impairment which has interfered with your ability to practice your specialty? __Yes __No

Are you presently using illegal drugs or substances or legal drugs or substances without a valid prescription? __Yes __No

If you answered yes to any of the above, please attach an explanation.

When was your last Child Abuse Clearance? (Date)___________________________

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SPECIALTY AREAS
(Please check off all areas in which you are qualified)

____	AB Abuse (Physical/Sexual)	____	GE Geriatric Disorders
____	AD Adjustment Disorders	____	HV HIV/AIDS Issues
____	AF Affective Disorders	____	MF Marital/Family
____	AL Alcohol	____	MN Men's Issues
____	AM Adjustment to Major Physical Illness and Disability	____	MD Medication Management Only
____	AN Anxiety Disorders	____	PD Personality Disorders
____	AT Attention Deficit/Hyperactivity	____	PH Phobias, Panic Disorder
____	BI Biofeedback/Relaxation Training	____	SD Sexual Orientation/Sexual Preference Issues
____	CD Chemical Dependence	____	SA Substance Abuse/Disorder
____	DD Dual Diagnosis (MI/CD)	____	SP Severely and Persistently Mentally Ill
____	DS Dissociative Disorders	____	TR Trauma/PTSD
____	DV Developmental Disorders		
____	ED Eating Disorders	____	WO Women's Issues
____	Other (Please specify below)		

________________________ ________________________

Are you a provider for other EAPs? ____Y ____N
List the EAPs:____
Are you able to offer a routine appointment within 3 business days? ____Y ____N
Do you provide crisis intervention services/ CISD?: ____Y ____N
Are you able to offer an urgent appointment within 1 business day? ____Y ____N
Are you able to offer appointments in the evening? ___ Y ___N
Are you able to offer appointments on the weekends? ___Y ___N

Do you provide Psychoeducational Groups? ____Y ____N
If yes, please list:____
____

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CLINICAL SERVICES (please check all that apply)

____ Outpatient Group Therapy
Specify Type:__________________
____
____
____

____ Outpatient Individual Therapy

____ Outpatient Family/Couples Therapy

____ Medication Management

____ Other (specify)____________
____

____ Psychological Evaluations

____ Neuropsychological Evaluations

____ Psychiatric Evaluations

____ Outpatient Substance Abuse Counseling

____ Case Management

____ Inpatient Care

____
____

PRACTICE POPULATIONS

____ Children (0-12)

____ Adolescents (13-17)

____ Adults (18-54)

____ Geriatric (55+)

Please submit copies of the following with this application:

____ Current State License(s)
____ Certifications (CADC, CAADC, DEA, RPT etc.)
____ Proof of malpractice liability coverage with specified amount (e.g. cover sheet)
____ Resume, CV or Bio

I certify that the information provided in this application is correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in denial of my application or termination from network participation.

____

Signature **Date**