PROVIDER INFORMATION FORM

First Name:		Last Name:		Male:			
				Female:			
Name of Practice:							
Primary Office Location:	Street Address:						
	City:		ST:		Zip		
Business Website:							
Email Address:							
Contact Information:	Office Telephone:		Office Fax:				
	Cell Phone:		Home Phone:				
What is Your Preferred Communication Method:	Email ☐ Telephone ☐ Cell Phone ☐ Text ☐						
Primary Mailing Address:	Street Address:						
	City:		State:		Zip:		
Office Setting: (please check one that applies)	Home Office		Business Office		Other: (please specify type)		
General Office Hours:							
Do you see clients in the evenings?	YES		Do you see clients on the weekends?	YES			
	NO			NO			
Are you available to do offsite visits (i.e. nursing home, residential)?	YES		Are you an EAP Service Provider?	YES			
				NO			
	NO		Are you EAP Certified?	YES			
				NO			
If you see patients in more than one more than one location, please list each additional office address below:							
2nd Office Location:	Street Address:						
	City:		ST:		Zip:		
Mailing Address:	Street Address:						
	City:		ST:		Zip:		
Home Address:	Street Address:						
	City:		ST:		Zip:		
# of Years in Practice:		Highest Degree:					
Professional Affiliations:							
Special Certifications/ Training: (please check all that apply)	Play Therapy		Psychoanalytic Therapy		EMDR	DBT	CBT
	Other:						

Please indicate the age groups you prefer to treat:	Infant		Preschool		Elementary		Adolescence	
	Young Adults		Adults		Elderly		Other	

Do you take court-mandated cases?	YES		Session Rate/Fee?	$	Do you have a sliding scale:	YES	
	NO					NO	

If you have a sliding scale, please describe:	

Have you ever been suspended/terminated from participation in a government benefits program?	YES	
	NO	
If yes, please attach an explanation of same:		
Have you ever been subject to discipline by a licensing authority?	YES	
	NO	
If yes, please attach an explanation of same:		
Have you ever been names as a defendant in a malpractice lawsuit?	YES	
	NO	
If yes, please attach explanation, along with a case name & docket number:		
Is there anything else you would like us to know about you and your practice?	YES	
	NO	
If yes, please describe below:		

Malpractice Insurance Information:	Effective Date:		Expiration Date:	
Clinical License Information:	Expiration Date:		Date of Birth:	
NPI #:			CAQH #:	

AREAS OF EXPERTISE

Please check all applicable areas of expertise under each category:

Addictive Disorders		**Children Teen Issues**		**Family Conflict**		**Mood Disorders**		**Neurologic Disorders**	
Alcohol		Bullying (victim)		Domestic Violence		Depression		TBI	
Drugs (legal)		Bully (perpetrator)		Marital/Couples		Anxiety		Alzheimer's	
Drugs (illegal)		Academic		Substance Abuse		Bipolar		Asperger's	
Dual Diagnosis		Oppositional/Defiant		Divorce/ Separation		Anger Mgmt.		Autism	
Gambling		Teen Violence		Parenting		Suicidal Ideation		ADHD	
Internet		Self-Harm		Relationship Issues		Post-Partum		Developmental Disorder	
Video Games		Peer Relationships		Gay/Lesbian					
Co-Dependency		Self-Esteem		Supervised Visitation					
Sexual		Gender Identify							
Recovery									

Personality Disorders		**Problems of Daily Living**		**Special Services**		**Serious Mental Illness**		**Trauma/ PTSD**	
OCD		Occupational		Medication Management		Schizophrenia		Military	
Borderline		Legal		Psych. Consultation		Axis I Diagnoses		Sexual Abuse	
Narcissistic		Health		Psychological				Physical Abuse	
Eating Disorders		Disability		Testing / Evaluation				Emotional Abuse	
		Bereavement		Sex Offender					
		Aging/Geriatric		LGBT					
		Financial							

Insurance Companies Provider Participates With

Please check all of the insurance companies you are currently participating in?

Aetna		Harvard Pilgrim		MHN		Tricare	
Anthem / BCBS		Medicare		Multi Plan		United Behavioral Health	
Beacon Health (Value Options)		*Medicare Advantage		Psych Care		United Health Care	
Cigna		*If Yes, Please Identify Which Type: _____		Optum		Other (Please list name)	
Connecticare		Husky (Medicaid)		Oxford		Other (Please list Name)	
Golden Rule		Magellan		TCI		Other (Please list name)	
Others, please identify:							

I certify that the above information is correct and accurate.

Clinician Signature: _____ Date: _____