PROVIDER INFORMATION FORM

First Name				Last Name:			
Professional License (*Please check all that apply):*							
APRN		LCSW		LPC		Psychiatrist	
LADC		LMFT		MD		Psychologist	
Other (please identify):							
Name of Practice:							
Primary Office Address:	Street Address:						
	City:		ST:		Zip:		
Email Address:			Website Address:				
Mailing Address (if different from primary office address):	Street Address:						
	City:		ST:		Zip:		
Contact Information:	Office Telephone:		Office Fax:				
	Cell Phone:		Home Phone:				
How do you see clients: *(check all that apply)*:	Telehealth Only		In Person Only		Both		
What is your preferred method of communication:	For GCR Staff to reach you regarding the referral *(check all that apply)*:	Office Phone		For Clients to reach you directly: *(check all that apply)*:	Office Phone		
		Cell Phone			Cell Phone		
		Email			Email		
If you see patients in more than one more than one location, please list each additional office address below:							
2nd Office Location (if applicable):	Street Address:						
	City:		ST:		Zip:		
Type of Office Setting: (please check one)	Primary Office (check one):	Home Office		Business office		Other: (List Type):	
	Secondary Office (check one):	Home Office		Business office		Other: (List Type):	
General Office Hours:		For Primary Location:					
		For Secondary Location:					
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	
# 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 that you 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 #:				
Home Address:							
City:			ST:		Zip:		

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/ First Health Network		Golden Rule		MHN		Psych Care	
Anthem / BCBS		Husky (Medicaid)		PHCS/Multiplan		Tricare / Humana Military	
Beacon Health		Magellan		Optum/United Health Care - Connecticare - Golden Rule - Harvard Pilgrim - Oxford Health Plans - UMR Wausau - Oxford		TCI	
Cigna / Cigna + Oscar		Medicare				Tufts / Allied Healthcare	
Connecticare Only (if not under Optum Plan)		*Medicare Advantage (Please List Medicare Advantage plan name(s) below)				Other (Please list Name)	

I certify that the above information is correct and accurate.

Clinician Signature: _____ Date: _____