PROVIDER DATA SHEET

COMPLETE FOR EACH INDIVIDUAL IN GROUP

PRACTICE/GROUP/FACILITY INFORMATION			
Practice/Group Name:			
Practice Address:			
City/State/Zip:			
Practice Phone:		Practice Fax:	
Is site a Residence?	☐ Yes ☐ No	Website:	
Billing Address:			
City/State/Zip:			
Biller Email:		Office Manager Email:	
Tax Identification #:		Group NPI #:	

PROVIDER INFORMATION			
First Name:		Last Name:	
Gender:		Ethnicity: (voluntary)	
Email Address:		Individual NPI #:	
State License #1		State License #2:	

SPECIALTIES (check all that apply)

☐ Abuse	☐ Compulsive Gambling	☐ Home Visits	☐ PTSD
☐ ADHD	☐ Co-Occurring Disorder	☐ Injectable Administration	☐ Schizophrenia
☐ Adoption Issues	☐ Couples/Marital	☐ Language Translation Svcs.	☐ Serious Mental Illness
☐ AIDS/HIV	☐ Depression/MDD	☐ Methadone	☐ Sex Offender Treatment
☐ Anger Management	☐ Dialectical Behavioral Therapy	☐ Military/Veterans	☐ Sexual Abuse (Adult)
☐ Anxiety/Panic/Phobias	☐ Dissociative Disorder	☐ Mood Disorder	☐ Sexual Abuse (Child)
☐ Bariatric Evaluation	☐ Domestic Violence	☐ Obsessive Compulsive Disorder	☐ Sleep Disorder
☐ Basic Skill Training (BST)	☐ Eating Disorder	☐ Parent Support	☐ Substance Use Disorder
☐ Bereavement/Grief	☐ ECT	☐ Peripartum Depression/PPD	☐ Telehealth
☐ Behavior Modification	☐ EMDR	☐ Personality DO	☐ TMS
☐ Bullying/Cyberbullying	☐ **Faith/Spirituality	☐ Play Therapy	☐ Transgender
☐ Buprenorphine	☐ Family	☐ Police/Firefighters	☐ Trauma
☐ Chronic Illness	☐ Gay/Lesbian/Bi-Sexual	☐ Psych Testing	☐ Visual Impairment
☐ Codependency	☐ Group Therapy	☐ Psychosis	
☐ Cognitive Behavioral Therapy	☐ Hearing Impaired	☐ Psychosocial Rehab/PSR	

Are you accepting new patients?	☐ Yes ☐ No	Have you completed Cultural Competency training?	☐ Yes ☐ No
Age Range:	☐ Pediatric (0-6) ☐ Child (6-12) ☐ Adolescent (12-17) ☐ Young Adult (17-24) ☐ Adult (24-64) ☐ Geriatric (65+)		
Language:	☐ Spanish ☐ French ☐ Tagalog ☐ Sign Language ☐ Other:		
**Specify Faith if checked above			
Other specialties:			

Hours: Check the day/s & provide hours below the selected day.	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday

Limitations:	
Hospital Privileges:	Are you hospital based? ☐ Yes ☐ No
Board Certifications:	

Please indicate if your Practice/Group /Facility has accommodations for people with physical disabilities.

Accommodation	Yes	No	Accommodation	Yes	No
Parking	☐	☐	ADA Scales	☐	☐
Exterior Building	☐	☐	ADA Exam Tables & Chairs	☐	☐
Interior Building	☐	☐	ADA Gurneys & Stretchers	☐	☐
Restroom	☐	☐	ADA Portable Lifts	☐	☐
Exam Room	☐	☐	ADA Radiologic Equipment	☐	☐
Exam Table/Scale	☐	☐	ADA Signage & Documents	☐	☐
ADA Exam Room & Equipment	☐	☐			
Other					