

PROVIDER DATA SHEET

PLEASE PRINT LEGIBLY WITH BLACK OR BLUE INK – COMPLETE FOR EACH CLINICAL PROFESSIONAL

PRACTICE/GROUP/FACILITY INFORMATION			
Practice/Group Name:			
Practice Address:			
City/State/Zip:			
Practice Phone:		Practice Fax:	
Is site a Residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hours of Operations:	
Billing Address:			
City/State/Zip:			
Biller Email:		Office Manager Email:	
Tax Identification #:		Group NPI #:	
Website:			

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

SPECIALTIES (check all that apply)			
<input type="checkbox"/> Abuse	<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Psychosocial Rehab
<input type="checkbox"/> ADHD	<input type="checkbox"/> Co-Occurring Disorders	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Adoption Issues	<input type="checkbox"/> Compulsive Gambling	<input type="checkbox"/> Home Visits	<input type="checkbox"/> Serious Mental Illness
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Couples/Marital	<input type="checkbox"/> Injectable Administration	<input type="checkbox"/> Sex Offender Treatment
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Depression	<input type="checkbox"/> Methadone	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Dialectical Behavioral Therapy	<input type="checkbox"/> MDD	<input type="checkbox"/> Sexual Abuse (Child)
<input type="checkbox"/> Bariatric Evaluation	<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> BST	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> OCD	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Behavior Modification	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Parent Support	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> ECT	<input type="checkbox"/> Personality DO	<input type="checkbox"/> Translation Services
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> EMDR	<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Trauma/Crime Victims
<input type="checkbox"/> Bullying/Cyberbullying	<input type="checkbox"/> Family	<input type="checkbox"/> PPD	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Fears/Phobia	<input type="checkbox"/> Psychosis	
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Gay/Lesbian/Transgender	<input type="checkbox"/> PTSD	
<input type="checkbox"/> Codependency	<input type="checkbox"/> Grief/Bereavement	<input type="checkbox"/> Psych Testing	
Are you accepting new patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you completed Cultural Competency training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age Range:	<input type="checkbox"/> Pediatric (Starting Age: _____) <input type="checkbox"/> Adolescent (13-17) <input type="checkbox"/> Adult (18-64) <input type="checkbox"/> Geriatric (65+)		
Language:	<input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Sign Language <input type="checkbox"/> Tagalog <input type="checkbox"/> Other: _____		
Other specialties			
Limitations:			
Hospital Privileges:	Are you hospital based? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Board Certifications:			

Please indicate if your Practice/Group /Facility has accommodations for people with physical disabilities.					
Accommodation	Yes	No	Accommodation	Yes	No
Parking	<input type="checkbox"/>	<input type="checkbox"/>	ADA Scales	<input type="checkbox"/>	<input type="checkbox"/>
Exterior Building	<input type="checkbox"/>	<input type="checkbox"/>	ADA Exam Tables & Chairs	<input type="checkbox"/>	<input type="checkbox"/>
Interior Building	<input type="checkbox"/>	<input type="checkbox"/>	ADA Gurneys & Stretchers	<input type="checkbox"/>	<input type="checkbox"/>
Restroom	<input type="checkbox"/>	<input type="checkbox"/>	ADA Portable Lifts	<input type="checkbox"/>	<input type="checkbox"/>
Exam Room	<input type="checkbox"/>	<input type="checkbox"/>	ADA Radiologic Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Exam Table/Scale	<input type="checkbox"/>	<input type="checkbox"/>	ADA Signage & Documents	<input type="checkbox"/>	<input type="checkbox"/>
ADA Exam Room & Equipment	<input type="checkbox"/>	<input type="checkbox"/>			
Other					