



ASSOCIATES

PROVIDER DATA FORM

Provider Name: _____ Discipline and licensure: _____

Group Practice Name (if applicable) _____

Person to contact for intakes: _____

Address 1: _____

_____ Fax: _____ Phone: _____

Address 2: _____

_____ Fax: _____ Phone: _____

Emergency Numbers: _____ Voicemail: _____ Email: _____

Male/Female: _____ Languages: _____ Ethnicity: _____

Please indicate all areas of special competency or interest:

<input type="checkbox"/>	Addictions	<input type="checkbox"/>	Women's Issues
<input type="checkbox"/>	DOT/SAP	<input type="checkbox"/>	Men's Issues
<input type="checkbox"/>	Anxiety and Panic	<input type="checkbox"/>	Gay/Lesbian
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	Dissociative Disorders	<input type="checkbox"/>	Critical Incident Debriefing
<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	Forensic Evaluations
<input type="checkbox"/>	Family Therapy	<input type="checkbox"/>	Stress Management
<input type="checkbox"/>	Couples Therapy	<input type="checkbox"/>	Medication Evaluations
<input type="checkbox"/>	Children	<input type="checkbox"/>	Sex Change
<input type="checkbox"/>	Adolescents	<input type="checkbox"/>	Other

Please identify all insurance reimbursement for which you are eligible, including HMO panels and Medicare. Please attach copies of the following: (1) Current State License; (2) Evidence of current malpractice insurance; (3) Current CV.

Fee Range: _____ Tax ID: _____

381 Elliot Street, Suite 180L ; Newton Upper Falls, MA 02464
(617) 969 - 7600 ; (800) 444 - 7262
FAX (617) 969 - 7646

Much of our work requires emergency response to such events as assaults and robberies. Please indicate your willingness to be available for such work, your experience or training in trauma response, and how to reach you in an emergency.

Documentation: Please attach copies of the following: (1) current state license; (2) evidence of current malpractice insurance; and (3) current CV.

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