



# CONCERNED associates

## Provider Application

► **PERSONAL INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Past/Current Professional name(s) used: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Highest Degree: \_\_\_\_\_ Discipline: \_\_\_\_\_ Licensed as: \_\_\_\_\_

County/State/Country of Birthplace: \_\_\_\_\_

U.S. Citizen?  Yes  No If no, status of Visa at the present time: \_\_\_\_\_

Native Language: \_\_\_\_\_ List Languages Fluent: \_\_\_\_\_

► **PRACTICE LOCATION /BILLING INFORMATION:**

Sole Provider  Group Provider Group/Business Name: \_\_\_\_\_

Tax I.D #: \_\_\_\_\_  Group ID or  Individual ID

If a group provider, are you accredited?  Yes  No  JCAHO  CARF  Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Office: Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Mailing/Billing:** (if different from primary office address)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Billing/Accounts Manager:** \_\_\_\_\_ Phone: \_\_\_\_\_

► PROFESSIONAL LIABILITY INFORMATION: Please Enclose Copy of Current Carrier.

Current Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Previous Carriers: Please list carrier (s) for the past 5 years.

Past Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

(if needed use a separate sheet and attach to submission form)

► PRACTICE INFORMATION:

List office hours: Monday through Sunday:

Mon.: \_\_\_\_\_ Thurs.: \_\_\_\_\_ Sun.: \_\_\_\_\_

Tues.: \_\_\_\_\_ Fri.: \_\_\_\_\_ or Weekly Hours: Mon. thru Fri.

Wed.: \_\_\_\_\_ Sat.: \_\_\_\_\_

Are you able to schedule clients for an initial appointment within 7 days of their first contact with your practice?  Yes  No If not, within how many days? \_\_\_\_\_

Do you provide 24-hour coverage?  Yes  No Night/Beeper/Answering Service #: \_\_\_\_\_

What is your procedure to handle after business hour calls?  
\_\_\_\_\_

Client Population: Please check the age ranges for which you serve.

Adult (19-64)  Adult (65 +)  Adolescent (13-18 years)  Child (6-12)  Child (1-5)

Are your office locations wheelchair/handicap accessible?  Yes  No

Is your office located within one block of public transportation?  Yes  No

Treatment Modalities/Approaches:

Please indicate modalities you currently employ in your practice:

Individual  Couple/Conjoint  Group  Family  EMDR  Psychotherapy

Biofeedback  Hypnotherapy  Solution-Focused Therapy  Brief Systemic

Internal Family Systems  Cognitive Behavioral/Rational  Relation Therapy

Reality  Experiential \_\_\_\_\_

Other: \_\_\_\_\_

► PRACTICE INFORMATION: Continued ...
Clinical Services for Specific Disorders

- ADHD/ADD Anxiety Disorders Adjust/Re-Adj.Disorders Mood Disorders
Psychotic Disorders Personality Disorders Psychosomatic/Somatoform Addictions
Trauma/Crisis Terminally Ill Grief/Bereavement Head Injury Patients
Chronic Pain/Illness HIV Positive Patients Sexual Disorders Eating Disorders
Post Traumatic Stress Others Not Listed:

Professional Society Memberships And/Or Fellowships
Name(s) and inclusive dates of memberships:

Name: Date:
Name: Date:
Name: Date:

► LICENSURE AND OTHER REGISTRATIONS/CERTIFICATIONS:
Please enclose copy (or copies) of licenses/registrations and certifications.

State: License # Title: Expiration Date:
State: License # Title: Expiration Date:
State: License # Title: Expiration Date:
State: License # Title: Expiration Date:

► EDUCATION/EXPERIENCE:

Please enclose vita/resume to provide information on employment experience, education, internship, or equivalent positions in chronological order. Employment history must include all positions held for the last five years. Please provide explanation for any gaps in history.

- Vita attached Resume attached (Not necessary to fill in the below information if a Vita or Resume is attached.)

Practice Name: Date:
Address:
Practice Name: Date:
Address:

(continued next page if needed.)

► EDUCATION/EXPERIENCE: *Continued ...*

Practice Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Education: \_\_\_\_\_ Date: \_\_\_\_\_

Education: \_\_\_\_\_ Date: \_\_\_\_\_

Education: \_\_\_\_\_ Date: \_\_\_\_\_

*Please attach sheet(s) to complete all relevant information and include gap of history information.*

► VOLUNTARY INFORMATION:

*Not only do customers often express preferences for therapists of a particular ethnic background or gender, but also employers may wish to determine if our network reflects the ethnic/gender profile of their employees. If you volunteer to provide the following information, it will be held in the strictest confidence. It will be used only when a customer indicates such information is important when selecting a provider or in the aggregate profile of our network.*

Gender:  Male  Female Ethnic Background: \_\_\_\_\_

► DISCLOSURE QUESTIONS:

*Please provide a complete, signed and dated explanation on a separate sheet if any of the following questions are answered in the affirmative. Thank you.*

- Yes  No 1. Have you ever been named in any malpractice action? *(this would include pending claims or lawsuits, dismissed or dropped claims/lawsuits, settlements and final judgements.)*
- Yes  No 2. Has your professional liability carrier ever cancelled your insurance or refused renewal?
- Yes  No 3. Has your professional license or registration or certification ever been terminated, suspended, voluntarily relinquished, refused, or not renewed by any licensing or certification board of any health related agency, or is there a review pending?
- Yes  No 4. Has your membership, participation, clinical privileges or employment ever been denied, terminated, restricted, refused, revoked, or not renewed by any peer review organization, third party payer, medical staff, or any health related agency, or is there a review pending?
- Yes  No 5. Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, misdemeanor (other than a traffic violation), or other offense involving fraud, misrepresentation, dishonesty or deceit?
- Yes  No 6. Have you ever been found liable, guilty or responsible for sexual impropriety, misconduct, or sexual harassment?
- Yes  No 7. Are you currently using illegal drugs?
- Yes  No 8. Do you have a condition that would affect your ability, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing significant health or safety risk to your clients?

▶ **ACKNOWLEDGEMENTS AND ATTESTATION**

I wish to participate in CONCERNED associates Provider Network. I hereby certify that all information in this application is complete, true and accurate. I further understand that information entered into this application which is subsequently found to be false could result in a change of my status as a provider and/or the cancellation of any contract or employment agreement I may have entered into with CONCERNED associates. If any material changes occur affecting my professional status, I understand it is my obligation to notify CONCERNED associates and I agree to do so in a timely manner.

▶ Print Name/Credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

▶ **CHECK LIST:**

- Copy Of Professional Liability Insurance Cover Sheet Enclosed?
- Copy Of Licenses/Registrations And Certifications Enclosed?
- Vita/Resume Enclosed?
- Diploma Enclosed?
- A Complete, Signed And Dated Explanation On A Separate Sheet If Any Of The Disclosure Questions Are Answered In The Affirmative, Enclosed?
- Application Is Signed And Dated.
- All Five (5) Pages of Application Are Enclosed.

▶ **SEND TO:**

**CONCERNED associates**  
Gil Garcia, MSW, ACSW, CEAP  
3612 13th Street,  
Menominee, MI 49858

▶ **QUESTIONS:**

- *Call:* (866) 903-6000 or *E-mail:* info@concernedassociates.com



*“Concerned for people in the workplace”*