

**Healthcare Professional Application**

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| **Name** | Click here to enter text. |

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| **Professional Designation(s)** | Click here to enter text. |
| *Choose from:* ***Physician, Nurse, Nurse Practitioner, Physician Assistant, Physical Therapist, Massage Therapist, Chiropractor, Naprapath or other (please specify).***  *(If more than 1 category applies, you may choose more than 1.) You must be an independently licensed/credentialed professional to be listed.* | |
| **Organization/Agency/Practice Name** | Click here to enter text. |
| **Main Address** |  |
| **Alternate Address(es)** |  |
| **City Location(s)/Neighborhood(s)** |  |
| **Suburb Location(s)** |  |
| **Phone Number & Extension** | **(            )                 -                                ext** |
| **Email Address** |  |
| **Website** |  |
| **Practice Specialty or Area of Expertise** |  |
| **Marginalized Populations You Serve** *(Circle all that apply)* | Poly/Consensual Non-monogamy  Kink/BDSM            LGBQ           Trans/T\*            Gender Non-conforming Sex Workers  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Provider Insurance(s) Accepted**  *(Circle all that apply; use “OTHER” to write in student plans, etc.)* | BCBS PPO      BCBS Blue Choice     BCBS HMO  Medicare   Medicaid      Tricare     Aetna PPO  United PPO    Cigna PPO  OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Do You Offer Sliding Scale Fees?** | YES            NO  LOWEST FEE ACCEPTED:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LOW FEE RANGE: $\_\_\_\_\_\_\_\_\_\_ -  $\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Is there other information, you would want listed?** If so, use this space to indicate. |  |