

**Provider Application Form**

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

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| **Provider Category(s)** | Click here to enter text. |
| *Choose from:* ***Psychiatrist, Solo Practitioner, Psychologist, Psychotherapist, Agency, Group Practice.***  *(If more than 1 category applies, you may choose more than 1.)* | |
| **Organization/Agency/Practice Name** | Click here to enter text. |
| **Provider Name (& Credentials)** | Click here to enter text. |
| *If Provider is associated with a group practice or agency, please include that info. If you are referring clients to a general agency or practice (i.e. The Family Institute), please include a contact name/Intake provider name if possible.* | |
| **Provider Main Address** |  |
| **Provider Alt Address(es)** |  |
| **Provider General City Location(s)/Neighborhood(s)** |  |
| **Provider General Suburb Location(s)** |  |
| **Provider Phone Number & Extension** | **(            )                 -                                ext** |
| **Provider Email Address** |  |
| **Provider Website** |  |
| **Provider Client Specialty** *(Circle all that apply)* | IND       REL        FAM       GROUP        ADOLESCENT      CHILD |
| **Provider Marginalized Population Specialty***(Circle all that apply)* | Poly/CNM            Kink/BDSM            LGBQ           T\*          GNC  OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Provider Offers Low Fee?** | YES            NO  LOWEST FEE ACCEPTED:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LOW FEE RANGE: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Provider Offers Sliding Scale?** | YES            NO  LOWEST AMT ACCEPTED:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SCALE RANGE: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Provider Clinical Expertise** *(Circle all that apply)* | Anxiety     Depression      Trauma     OCD      Eating Disorders   Psychotic Disorders     Personality Disorders    ADHD     DV  Substance Use     Psych Assessment  Sex Therapy     Infidelity  Autism     Dev/Learning Disabilities     Postpartum   Infertility  OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |