California Mental Health

We Provide Quality Behavioral Health Services throughout California

Practice Profile Intake Form

Name of Provider: _____

Licensure: _____ **State of Licensure:** _____

Email Address: _____ **Website:** _____

Primary Office Practice Location(s):

1. _____

2. _____

Please attach a separate sheet of paper listing additional locations.

County: _____ **Phone:** _____ **Fax:** _____

NPI: _____ **Business License:** _____

Are you registered with CAQH?
(Coalition for Affordable Quality Healthcare)? □Yes □ No

If "Yes," what is your CAQH Provider ID number? _____

Can you conduct therapy in any language(s) other than English? □ Yes □ No

If yes, please specify language(s): _____

Are you currently accepting new clients? □Yes □ No

Office Hours	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Please select the types of services you offer, including the disorders you treat in your practice.

Type of Services	
□ Individual Therapy	□ Ages of Children:
□ Couples Therapy	□ Parenting Support
□ Family Therapy	□ Psychological Testing
□ Group Therapy	□ Other:
Treatment Approaches	**Disorders/Issues**
□ ABA (Applied Behavior Analysis)	□ ADD/ADHD
□ Biofeedback	□ Adjustment Disorders
□ Client Centered Therapy	□ Anxiety Disorders
□ Cognitive Behavioral Therapy	□ Autism Spectrum
□ Dialectical Behavioral Therapy	□ Disruptive Behavior Disorders
□ EMDR	□ Dissociative Disorders
□ Family Systems	□ Eating Disorder
□ Gestalt	□ Impulse Disorders
□ Hypnosis	□ Mood Disorders
□ NLP	□ Personality Disorders
□ Outcomes Oriented Therapy	□ Physical Abuse
□ Play Therapy	□ PTSD
□ Psychoanalytic	□ Schizophrenia
□ Rationale Emotive Therapy	□ Sexual Abuse (Adults)
□ Tobacco Cessation	□ Sexual Abuse (Children)
□ Trauma Focused-CBT	□ Sexual Disorders
□ Other (please Specify)	□ Substance Abuse/Dependence Disorders
□ Methadone/Suboxone Medication Services	□ Other (please specify)

Please attach a separate sheet of paper listing additional information..

Describe your strengths as a therapist.

_____

_____

_____

_____

_____

_____

_____

Check the preferred clients you would like us to refer.

- Children
- Teens
- Married Couples
- Family
- Parenting Help
- Individuals
- Faith Based
- Drug and Alcohol Abuse
- Sexual Abuse
- Seniors
- Other _____

Are you currently credentialed with insurance companies? □ Yes □ No

List of insurance companies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please attach a separate sheet of paper listing additional insurance companies.

□ **Resume:** Send a resume that is current. Include the schools from which you received your degree and other relevant educational background.
□ **Credentialing Process:** Please understand that the consideration process is based on the group and the insurance company's needs. It can take up to 6 weeks to review your information. If the group's need is determined, an agreement will be sent to you from the group. If the group's need has not been determined, you will be notified by email and can re-submit for consideration in 4 months.

□ Send a Picture of yourself
□ Send a picture of your office space

Provider's Signature:

_____

Date: _____