(office use only) **PR #:** ______________________

Address Change: ☒ **YES** ☐ **NO**

Additional Office: ☐ **YES** ☒ **NO**

Practitioner Name: ________________________________ **License Level:** ____________

PRACTICE INFORMATION

PRACTICE LOCATION EFFECTIVE AS OF:	Primary Office Contact 1:	Federal Tax ID Name As Registered With IRS for Tax ID:		
Practice Name 1:.				
Practice Address 1: Street	City	County	ST	Zip
Mailing Address 1: Street	City	County	ST	Zip
Phone Number 1:	**FAX Number 1:**		**EMER # 1:**	
Email Address:				

It is PBH's policy that its providers maintain clean and professional settings in which to see their patients, as well as maintain confidentiality and accessibility for all patients. Please answer the following questions regarding your office:

1. **Does your office have a waiting room?** ☐ Yes ☐ No

If no, please describe your plan to ensure confidentiality – include information regarding arrival/departure for appointments:

2. **Is your office soundproof? (i.e. unable to hear content of therapy sessions/conversation in adjoining rooms, waiting room, or administrative area) – white noise & music are acceptable.** ☐ Yes ☐ No

3. **Are medical records kept in a secured locked area? *Please describe where records are kept and who has access*:** ☐ Yes ☐ No

4. **If you prescribe medications – are they kept in a locked area or cabinet?** ☐ Yes ☐ No ☐ N/A

***Please describe location*:**

5. **If you prescribe medications – are prescription pads kept in a locked or secure area?** ☐ Yes ☐ No ☐ N/A

***Please describe location*:**

Return to: ______________________
PacifiCare Behavioral Health, Incorporated

6. **Is your office accessible to the physically handicapped?** ☐ Yes ☐ No

If your answer is no, would you be able to make accommodations if/when needed? ☐ Yes ☐ No

Please describe:

7. **Do you have adequate parking –** ☐ Yes ☐ No

Please describe your parking accommodations for patients:

8. **Are all of your practice locations in a professional/business/commercial zone? (i.e. not residential)** ***If your answer is no, please explain – and answer additional questions below***: ☐ Yes ☐ No

 a) **Is your office separated from living quarters by a locked door or barrier?** ☐ Yes ☐ No ☐ N/A

 b) **Are the bathroom, waiting room, and any transition space separate from all living space and only utilized by patients (not used by family members)?** ☐ Yes ☐ No ☐ N/A

 c) **Does your office have a separate entrance from residence?** ☐ Yes ☐ No ☐ N/A

 d) **Is anyone else home during your business/session hours?** ***If yes – please explain how you ensure privacy & confidentiality of patients***: ☐ Yes ☐ No ☐ N/A

 e) **Do you have a separate business phone line or answering service?** ***If no, please explain***: ☐ Yes ☐ No

9. **Please provide a brief description of office layout to explain questions 8 a-c. Attach and use additional sheets as needed:**

Emergency contact provided by: ☐ Pager ☐ Ans. Service ☐ Ans. Machine with Pager ☐ Other:

Normal Business Hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

**** If sent to practitioner for verification:***

By signing below I attest that all of the information submitted herein is true and complete.

Signature: ______________________ Date: ______________________

Signature stamps cannot be accepted

Print Name: ______________________

**** If verified via telephone:***

Verbal Verification with Practitioner on (date): ____________

Name/Title: ______________________ Signature: ______________________

Return to: ______________________
PacifiCare Behavioral Health, Incorporated