

## LOCATION INFORMATION FORM

**\*\*\*Please complete for one form for each location\*\*\***

Facility Name \_\_\_\_\_

Location Address \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Title \_\_\_\_\_

Check One: Solo Practice \_\_\_\_\_ Group Practice/ Number of Doctors \_\_\_\_\_

Please List Names of All Doctors Practicing at this Location: \_\_\_\_\_

Office Size (in sq. feet): \_\_\_\_\_ # of Treatment Tables: \_\_\_\_\_

Number of Examination Rooms: \_\_\_\_\_

X-Ray Certification (Yes/No): \_\_\_\_\_ Last Date Certified: \_\_\_\_\_

Type of Facility: Free Standing \_\_\_\_\_ Medical Bldg. \_\_\_\_\_ Office Bldg. \_\_\_\_\_

Storefront \_\_\_\_\_ Other \_\_\_\_\_

Does Your Office Provide For Handicap Access? \_\_\_\_\_

Emergency(Urgent Care) Service? (Yes or No) \_\_\_\_\_ If Yes, By Whom? \_\_\_\_\_

24 Hour Method of Access: Answering Service: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Number \_\_\_\_\_ Other: \_\_\_\_\_

Do You Provide Physiotherapy On-Site? \_\_\_\_\_

If No, do you have a Referral Affiliation with a Physiotherapy or Rehabilitation Facility? \_\_\_\_\_

Do You Have Ownership In These Facilities? \_\_\_\_\_

### **PRACTICE INFORMATION:**

Patients are seen within \_\_\_\_\_ hrs./days for Urgent Care & \_\_\_\_\_ hrs./days for Non-Urgent Care.

Do you take History, Physical, and X-Rays at the Initial Visit for all Patients? \_\_\_\_\_

Do you Routinely Prepare a Written Plan of Treatment During your Initial History & Physical? \_\_\_\_\_

Do you have Ownership in any Facility/Place/Practice to which you Refer Patients? \_\_\_\_\_

If Yes, Please Describe: \_\_\_\_\_

Since Practicing, Has There Ever Been Greater Than A Thirty Day Period In Which You Did Not Practice? \_\_\_\_\_ If Yes, Please Explain: \_\_\_\_\_