Initial Application part 2
PROVIDER LOCATION INFORMATION

Office Contact Name_______________________________ Title_______________________________

Check One: Solo Practice____________ Group Practice/ Number of Doctors______________________

Please List Names Of All Doctors Practicing At This Location: ________________________________

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Office Size (in sq. feet): ________________________ # Of Treatment Tables: ____________________

Of Examination Rooms: _________________

Georgia X-Ray Certification (yes or 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 and ________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 And 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: ____

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REFERENCES

Please list two Professional References: Name, Address, Telephone Number

1)____

2)____