

Formal Education

Type	Institution Name	Year Grad.
Medical Degree		
Internship(s)		
Residency(ies)		
Fellowship(s)		

Specialties

Please refer to the list of available Board Certified Specialties.

Specialty	Board Certified? Y/N	Accepting Referrals? Y/N

Areas of Interest

If there are any special areas of expertise in which you are credentialed or have received additional training, please indicate so below:

Affiliation

Please mark below (with an 'X') those affiliation(s) you participate in:

	All Affiliations	Primary Affiliation
Enumclaw Regional Medical Center, Enumclaw	<input type="checkbox"/>	<input type="checkbox"/>
St. Anthony Hospital, Gig Harbor	<input type="checkbox"/>	<input type="checkbox"/>
St. Clare Hospital, Lakewood	<input type="checkbox"/>	<input type="checkbox"/>
St. Francis Hospital, Federal Way	<input type="checkbox"/>	<input type="checkbox"/>
St. Joseph Medical Center, Tacoma	<input type="checkbox"/>	<input type="checkbox"/>

Medical Group

Please mark below (with an 'X') those IPA(s) you participate in:

	All IPAs	Primary IPA
Franciscan Health System Medical Staff (non-employed)	<input type="checkbox"/>	<input type="checkbox"/>
Franciscan Medical Group (Employed)	<input type="checkbox"/>	<input type="checkbox"/>

Cash Payments

If you accept cash (or equivalent) as primary payment, please mark below (with an 'X') those payment forms you accept.

Credit Cards:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
Direct Payment:	<input type="checkbox"/> Cash	<input type="checkbox"/> Check		

Payment/Insurance Categories

Please mark below (with an 'X') those payment/insurance categories you accept or participate in:

Plan Types:				
<input type="checkbox"/> Commercial/Indemnity	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	<input type="checkbox"/> EPO	<input type="checkbox"/> Medicare
<input type="checkbox"/> Medicare Assignment	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Workers Comp.	<input type="checkbox"/> Champus	

Specific Insurance Information

<input type="checkbox"/> CHAMPUS (GENERAL)	<input type="checkbox"/> MEDICARE ASSIGNMENT (GENERAL)
<input type="checkbox"/> EPO (GENERAL)	<input type="checkbox"/> MEDICARE/MEDICAID (GENERAL)
<input type="checkbox"/> HMO (GENERAL)	<input type="checkbox"/> POS (GENERAL)
<input type="checkbox"/> INDEMNITY (GENERAL)	<input type="checkbox"/> PPO (GENERAL)
<input type="checkbox"/> MEDICAID (GENERAL)	<input type="checkbox"/> Self-Insured Employer Group (GENERAL)
<input type="checkbox"/> MEDICAID ASSIGNMENT (GENERAL)	<input type="checkbox"/> WORKERS COMPENSATION (GENERAL)
<input type="checkbox"/> MEDICARE (GENERAL)	

Office Information

Primary Office (make copies of this form for additional offices)

Name of Practice: _____

Address1: _____

Address2: _____

City: _____ State: _____ Zip: _____

Closest cross streets: _____

Voice Phone Number: (_____) _____ - _____

Fax Phone Number: (_____) _____ - _____

What time zone is in effect at this office (Eastern, Central, Mountain, Pacific, etc.)? _____

Does this location honor Daylight Savings Time(Y/N)? _____

What days/hours will someone be at this office to assist with scheduling?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

Please indicate whether or not you generally see patients during the time frames indicated below:

Note: Specific appointment time availability will be determined at the time the referral is made.

<input type="checkbox"/> Weekdays	<input type="checkbox"/> Evenings	<input type="checkbox"/> Saturdays	<input type="checkbox"/> Sundays
-----------------------------------	-----------------------------------	------------------------------------	----------------------------------

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Is public transportation available to this location Yes No

Is this location handicap accessible Yes No

What is the average new patient fee for a patient's first visit to this location? _____

What foreign languages, if any, are spoken at this location?

Language	Spoken by Provider	Spoken by Staff
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Physician Signature: _____ Date: _____