

Address Information

[Please copy this page and complete for each additional address, or if your preferred mailing address differs from your office address(es)]

Location Information

Payments / Correspondence / Mailing Address

Office (Physical) Address

Legal Entity Name:

DBA Name:

Address Street #:

Address Street Name:

Address Suite #:

City:

State:

ZIP:

County:

Country:

Office Phone #:

Mobile Phone #:

Fax #:

Please indicate and explain your procedure for ensuring that clients have 24 hour access to clinical services. _____

Beeper:

Share Call:

Answering Service:

Office Email:

Office Manager:

Start Date (mm/dd/yy):
(at this location)

Languages Spoken:

Office Hours

Mon:

Tues:

Wed:

Thurs:

Fri:

Sat:

Sun:

Is this office ADA Handicapped Accessible?:

Yes No

(If yes – please complete attached ADA Attestation)

Building: Yes No

Parking: Yes No

Restroom: Yes No

Accessible to Public Transportation:

Yes No

Bus: Yes No

Subway: Yes No

Train: Yes No