

Cameron and Associates, Inc. – Affiliate Group Application

Providers must submit updated copies of licenses and Malpractice Insurance Face Sheets at time of renewal.
*Please Note: *All areas must contain a response. If not applicable, 'N/A' should appear.*

SECTION I – GROUP DATA

A. Group Name: _____

Group Type: Partnership____ Corporation____ LLP____ LLC____ P.C.____

B. Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Web Address: _____

Tax ID of EIN#: _____

SECTION II – PROVIDER DATA

A. Provider Name: _____ Title: _____

License Discipline: Psychiatrist (M.D.) ____ Psychologist (Ph.D., Psy.D.) ____ LCSW ____ LPC ____
LMFT ____ Other (Please specify): _____

B. Affiliate Type: (Please select all that apply)

EAP ____ PPO ____

C. Date of Birth: / / Gender: Female/Male

Ethnicity: __African American __Asian __Caucasian __Hispanic __Native American __Other

SECTION III – PRACTICE DATA

A. Primary Location:

Site Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

B. Secondary Location:

Site Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Hours of Operation (Please indicate actual practice hours held each day)

MON. _____ TUE. _____ WED. _____

THURS. _____ FRI. _____ SAT. _____

Is your office handicap accessible? Y/N

(This information must be submitted for all participating providers. Attach a page of additional names.)

A. Federal DEA # (M.D.s and RNs) _____ Expiration Date (mm/dd/yy): _____

B. State DEA # (M.D.s and RNs) _____ Expiration Date (mm/dd/yy): _____

C. Board Certification # (MDs only): _____ Specialty: _____
Date Certified: _____

D. Areas of Practice: Please indicate the percentage of patients from the following categories within your practice and the percentage of your time dedicated to these treatment modalities.)

Population	% of Practice	Modality	% of Practice
Child	_____	Inpatient	_____
Adolescent	_____	Day Tx	_____
Adult	_____	Outpatient	_____
Geriatric	_____	Intensive Outpatient Programs	_____

F. Languages Spoken: (Please list only languages in which you are fluent)

___ Arabic (AR) ___ Chinese (CH) ___ Farsi (Persian) (FA) ___ French (FR) ___ German (GE)
___ Hebrew (HE) ___ Hindi (HI) ___ Italian (IT) ___ Japanese (JA) ___ Russian (RU)
___ Spanish (SP) ___ Vietnamese (VI) ___ Sign Language (SL) _____ Other (OT)

Call Coverage:

All Practitioners providing care for CAI clients must arrange for twenty-four (24) hour call coverage. Services performed in your absence for patents are subject to the terms of the participating practitioner's agreement.

I. Do you provide 24 hour call coverage? _____ Yes _____ No

Name: _____ Licensure: _____ Phone #: _____

II. After – Hours Answering Phone Service:

Name: _____ Phone #: _____

SECTION IV – PROFESSIONAL AFFILIATIONS

A. List hospitals where your MDs have staff privileges and type of privilege:

Hospital/Address	Type of Privileges			
_____	Full _____	Courtesy _____	Restricted _____	Other _____
_____	Full _____	Courtesy _____	Restricted _____	Other _____
_____	Full _____	Courtesy _____	Restricted _____	Other _____

B. List all current contracts with HMO, IPA, or other managed care companies:

Name/Address of Company	Approximate % of Practice
_____	_____
_____	_____
_____	_____

SECTION V – CLINICAL PSYCHOTHERAPEUTIC EXPERTISE

A. Treatment Modalities: Are there special treatment modalities that can facilitate appropriate referral and expedite treatment goals? ___ Yes ___ No Check at least 3 areas listed below for which you have had training and/or experience and how much training/experience you have had. **Required**

1. Training – A minimum of six (6) months supervised training
2. Experience – A minimum of one (1) year experience treating patients with this type of modality.

___ Adolescent Therapy	___ Christian Therapy	___ Family Therapy
___ Behavioral Therapy	___ Cognitive Therapy	___ Geriatric Therapy
___ Biofeedback	___ EAP	___ Group Therapy
___ Child Therapy	___ ECT	___ Psychopharmacology

SECTION V. CONTINUED

B. Clinical Specialties: Please select up to ten (10) area listed below in which you have training and experience and rate each for referral preferences (**1= Most Preferred / 10= Least Preferred**)

- | | | |
|--------------------------------|-------------------------------|------------------------------|
| _____ ADHD | _____ Ethnic/Cultural Issues | _____ Chronic Mental Illness |
| _____ Domestic Violence | _____ School Related Problems | _____ Gay/Lesbian |
| _____ Alcohol/CD | _____ Forensics | _____ Sexual/Physical Abuse |
| _____ Adol. Behav. Disorders | _____ Personality Disorders | _____ Eating Disorders |
| _____ Grief/Bereavement | _____ Step/Blended Families | _____ Disabilities |
| _____ Chronic Pain | _____ Head Trauma | _____ Stress Management |
| _____ Chronic/Terminal Illness | _____ Hearing Impaired | _____ Women’s Issues |
| _____ Crisis/Trauma | _____ Marital/Sep/Divorce | _____ Work Related Stress |
| _____ Men’s Issues | _____ Children | _____ Dissociative Disorders |
| _____ Anger Management | _____ Anxiety Disorders | _____ Bipolar Disorder |
| _____ Dissociative Disorders | _____ OCD | _____ ODD |
| _____ PTSD | _____ Schizophrenia | _____ Sleep Disorders |
| _____ Christian Counseling | _____ CISD | _____ SAP certified |
| _____ Other (please explain) | | |

Briefly state your theoretical and practice orientation in the treatment of Mental Health/Substance Abuse Problems.

SECTION VI – CURRENT MEDICAL MALPRACTICE INFORMATION

- A. Type of Coverage:** _____ Group _____ Individual
- B. Carrier:** _____ **Policy #:** _____
- C. Coverage Amount:** _____ **Policy Issue Date:** _____ **Renewal Date:** _____

SECTION VII – PROOF OF DOCUMENTATION

Copies of the following documents must be enclosed with this application:

Current Malpractice Face Sheet (photocopy)
Current License/Certification (photocopy)
Current DEA Certificate *M.D.s only* (photocopy)
Copy of current of Curriculum Vitae or Resume

Additionally, the applicant must provide primary source verification for the following items:

Ten-Year liability claims history (from your malpractice carrier)
MSN verification form (nurses only)
Board Certification for M.D.s

Attestation

I hereby attest that the information contained in the application is complete and accurate, I further understand that falsifying any of the information included in the application is grounds for termination of any contract entered into the Cameron and Associates, Inc.

I agree to maintain my professional liability insurance as describe in the application.

I agree to accept the fees listed in the fee schedule, and agree not to charge patients with additional charges beyond what is permitted under the fee schedule. I agree to abide by all policies and procedures of Cameron and Associates, Inc.

Signature

Date

Please submit completed forms to the following address:

Cameron and Associates, Inc.

Attn: Provider Relations Department

6100 Lake Forrest Drive

Suite 550

Atlanta, GA 30328

P.R. Direct: (404) 843-4861 CAI Main: (404) 843-3399 or (800) 334-6014

Authorization to Verify Information

In order to attain appropriate quality standards, Cameron and Associates, Inc. must verify certain information through Primary Source Verification. This may include, but is not limited to written reports from applicant's graduate school, malpractice insurance carrier, and the National Practitioner Data Bank (NPDB). NPDB is a federally funded administrative body that gathers and distributes information regarding the professional credential of healthcare providers, as well as malpractice claims against healthcare providers and sanctions against, and the loss of license by healthcare providers.

Applicants are notified in writing of any adverse information arising from Primary Source Verification that may affect acceptance into Cameron and Associates, Inc.'s Managed Behavioral Healthcare Network. At the time of such notification, copies of policies and procedures related to this Component of the application process, including policies and procedures for the filing of a written appeal of or challenge to any decisions based upon this information will be forwarded to the applicant. An appeal process will include the provision of a fair hearing to the applicant to allow the applicant the opportunity to correct erroneous information in accordance with all applicable state and federal laws.

Applicants may also view any information in support of their application. In order to review any information, applicants must submit a written request specifying which information is requested. To protect the right to privacy of all practitioners, this request must be notarized, thus attesting to the identity of the person submitting the request.

Please review the following authorizing statement, then sign below to indicate your acceptance of the authorizing statement and your acknowledgement of having been advised of your rights to review credentialing information.

I hereby authorize Cameron and Associates, Inc. and/or its designee to obtain and verify information contained on my application. I further consent to the release of any information that may be utilized to support my application, or that reasonably may be relevant to an evaluation of the suitability for the tasks and functions involved in being a member of the network of practitioners managed by Cameron and Associates, Inc. In the event that information is released to Cameron and Associates, Inc. and/or its designee, I agree to hold harmless from any cause of action based on the release of such information any person, organization or other entity, responsible for the release.

Signature

Date

Print Name

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