

Kinnamon Associates

1425 Spruce Street, Suite 100
Philadelphia, PA 19102
Telephone: 215-732-5160
Fax: 215-732-1682
Web: www.kinnamon.com

Practitioner Application

Last Name: _____ Degree (1): _____
First Name: _____ Degree (2): _____
Date of Birth: ____/____/____ Gender: Female Male
Social Security Number: ____-____-____ Citizenship: _____
Residence Address: _____
Email Address: _____@_____ Beeper Number: ____-_____
MEDICARE Number: _____ MEDICAID Number: _____
(Required, if applicable) _____
UPIN Number: _____
(Required, if applicable) _____

Licensure

Do you hold a professional license to practice independently within your state? Yes No

What year did you first receive your professional license? ____/____/____

What state granted your professional license? _____

What is the type of your professional license? _____

What is your professional license number? _____

What is the expiration date of your professional license? _____

Are you a Certified Employee Assistance Professional (CEAP)? Yes No

Are you a member of the Employee Assistance Professional Association (EAPA)? Yes No

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1320 Race Street
Philadelphia, Pa. 19107
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Fax: 215-564-9404
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Psychiatrists/Physicians

DEA Number : _____ Expiration: ____/____

Board Eligible: Yes No Date: ____/____

Board Certified: Yes No Date: ____/____

Area of Specialty (1): _____ Sub-Specialty: _____

Residency Institution: _____ Completed: Yes - Year: ____ No - Year: ____

Complete Address: _____

Date Attended: ____/____ To ____/____

Board Certified: Yes No Date: ____/____

Area of Specialty (2): _____ Sub-Specialty: _____

Residency Institution: _____ Completed: Yes - Year: ____ No - Year: ____

Complete Address: _____

Date Attended: ____/____ To ____/____

Board Certified: Yes No Date: ____/____

Voluntary Information

Completion of the following information is entirely voluntary and shall in no way affect Participation with Kinnamon Associates' provider network. Any information provided shall be used solely for purposes of clinical referral where cultural and/or linguistic preferences and/or needs are requested by the member or presented to Kinnamon Associates. Kinnamon Associates is an equal opportunity provider and does not discriminate based on any of these categories or any other category protected by either state or federal law.

Race/Ethnic Group:

- African American
- Asian/Pacific Islander
- Chinese
- Caucasian
- Hispanic
- Native American

Language Fluency:

- Arabic
- Chinese
- German
- Greek
- Polish
- Russian
- Spanish
- Sign
- Other - _____

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Billing Information

Individual/Group Name for Checks Payable: _____
Federal Tax Identification Number: _____
Billing/Mailing Address: _____
Telephone Number: _____ - _____
Fax Number: _____ - _____

Location and Hours of Operation

Office - Site One

Office Address: _____
County: _____
Telephone Number: _____ - _____
Fax Number: _____ - _____

Office - Site Two

Office Address: _____
County: _____
Telephone Number: _____ - _____
Fax Number: _____ - _____

Site One	Site Hours:	Provider Hours:
Monday	_____ to _____	_____ to _____
Tuesday	_____ to _____	_____ to _____
Wednesday	_____ to _____	_____ to _____
Thursday	_____ to _____	_____ to _____
Friday	_____ to _____	_____ to _____
Saturday	_____ to _____	_____ to _____
Sunday	_____ to _____	_____ to _____

Site Two	Site Hours:	Provider Hours:
Monday	_____ to _____	_____ to _____
Tuesday	_____ to _____	_____ to _____
Wednesday	_____ to _____	_____ to _____
Thursday	_____ to _____	_____ to _____
Friday	_____ to _____	_____ to _____
Saturday	_____ to _____	_____ to _____
Sunday	_____ to _____	_____ to _____

Site One Information

Handicap Accessible: Yes No
Public Transportation Access: Yes No

Site Two Information

Handicap Accessible: Yes No
Public Transportation Access: Yes No

Please describe your After Hours/On-Call coverage: _____

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Clinical Subspecialties for Referrals

Kinnamon Associates' Professional Provider Advisory Committee privileges clinical subspecialties for the purpose of referral. Please check those areas of subspecialty you wish to be considered as being competent to serve based upon related licensure, education, training, certification, and/or experience. Sufficient documentation of licensure, education, training, certification, and/or experience must be attached to this application in order to be privileged in subspecialties listed in **bold** print.

Please note: In accordance with the ethical treatment of clients, providers should render services that do not exceed the limits of their license, education, training, certification or other related professional experience and should accurately and truthfully represent their areas of subspecialty below for purposes of appropriate, clinical referral.

Populations Served

- Early Childhood
- Adolescents
- Latency
- Young Adults
- Middle Adults
- Aging Adults

Treatment Modalities

- Individuals
- Couples
- Families
- Groups
- Hypnosis/Hypnotherapy**
- Psychological Testing
- Other: _____

Diagnostic Categories Served

- Chemical Dependency Disorders**
- Eating Disorders**
- Disorders of Early Childhood**
- Disorders of Latency
- Disorders of Adolescence
- Geriatric Disorders**
- Organic Disorders
- Psychotic Disorders
- Delusional Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders**
- Sexual Dysfunction Disorders**
- Sleep Disorders
- Impulse Control Disorders
- Attention Deficit/ADHD
- Marital/Relational Problems
- Family Problems
- Grief-Related Problems
- Obsessive Compulsive Disorder**
- Phobic Disorders
- Gender Identity Disorders
- Disability Evaluations (physicians only)
- Disability Treatment
- Personality Disorders

Specialty Issues

- Women's Issues
- Men's Issues
- Gay/Lesbian Issues
- Chronic Illness
- Sexual Abuse
- Pain Management
- Physical Abuse
- Racial/Ethnic Minority Issues
- Death/Dying Issues
- Pastoral Counseling
- Trauma/PTSD
- Critical Incident Debriefing**
- Management Consults
- Hearing Impaired
- DOT Regulations
- Substance Abuse Professional**
- AIDS
- Employee Assistance Professional**
- Other: _____

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General Affiliations

- Do you provide services for any other Managed Care Organizations? Yes No
If Yes, please attach a listing that includes name and location.
- Do you provide services for any other Employee Assistance Program? Yes No
If Yes, please attach a listing that includes name, location, and nature of relationship.
- Are you affiliated with or do you have admitting rights to any hospital, facility or program? Yes No
If Yes, please attach a listing that includes name, location, and type.

Sanction, Legal, and Regulatory Activity

Please check **Yes** or **No** to each of the following questions and provide documentation for all questions answered **Yes**.

1. Have there ever been any actions taken against your professional license, including but Not limited to restriction, limitation, denial, revocation, suspension, or cancellation in any state? Yes No
- Is there action pending? Yes No
2. Has your DEA registration ever been restricted, limited, reduced, denied, suspended or cancelled? Yes No
3. Have you ever relinquished your professional license or DEA registration? Yes No
4. Has any facility, program, HMO, or other healthplan ever limited, denied, revoked or restricted your professional privileges? Yes No
5. Have you ever been the subject of corrective action as a member of any facility, program or medical staff? Yes No
6. Have you ever been convicted of a felony? Yes No
7. Has your membership in any professional society or association ever been cancelled, revoked or censured for any reason other than for Non-payment? Yes No
8. To your knowledge, have there been, or are there currently, any judgements, settlements, findings, decisions, or any other determinations of any kind whatsoever entered or made in any medical professional misconduct proceedings wherein you were a part in this state or any other state? Yes No
9. Have Medicare, Medicaid, peer review organization authorities or any other medical reimbursement plan ever brought formal charges against you for alleged inappropriate billing practices or quality of care issues? Yes No
10. Have you ever lost your board certification or failed to re-certify? Yes No
11. Within the past five years, have you ever been convicted of or pleaded guilty to a felony? Yes No
12. Do you suffer from any physical or mental condition which impairs your ability to practice? Yes No
13. Presently, are you using any illegal drugs? Yes No
14. Within the past five years, have you ever been denied professional liability insurance; has your insurance ever been cancelled; has the renewal ever been refused; have premiums been surcharged because of claims? Yes No
15. During the past five years, have you ever been party to malpractice suits, which went to final disposition and resulted in payment to the plaintiff? Yes No
16. Presently, are there any malpractice suits pending against you? Yes No
- If the answer is Yes, please complete the following:

Number of Suits: _____

Nature of alleged malpractice:

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Sanction, Legal, and Regulatory Activity (Continued)

Outcome:

Additional comments:

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Practitioner Attestation

I certify that the information I have provided about myself is true and accurate to the best of my knowledge. I warrant that I experience no physical or mental impairment, nor do I experience impairment due to substance abuse. I grant Kinnamon Associates and/or its agents permission to verify the information given. I understand that if I have omitted damaging information or misrepresented any facts, Kinnamon Associates may cancel any arrangement that we have in force at the time, contractual or otherwise.

I have been informed by Kinnamon Associates that my credentials are being evaluated. I grant Kinnamon Associates and its authorized representative and/or agent permission to contact any individuals, institutions, or agencies, which may possess any relevant information as a part of this application process. I also grant Kinnamon Associates and its authorized representative and/or agent permission to obtain copies of documents from individuals, institutions or agencies which may possess any information relevant to my credentialing/recredentialing.

I understand that I as an applicant to Kinnamon Associates, have the burden of producing adequate information for the proper evaluation of my credentials, including professional competence, character, ethics and other qualifications and I am responsible for resolving any doubts about such qualifications.

I also grant my permission to Kinnamon Associates to perform an on-site review of my practice location(s) and obtain copies of any information relevant to the application/reapplication process.

I agree to notify Kinnamon Associates if any information provided on this application changes. Said notice shall be in writing and submitted to Kinnamon Associates within thirty days after the information provided on the application changes.

By applying for participation with Kinnamon Associates I:

release from liability all representatives of Kinnamon Associates for their acts performed in good faith and without malice in connection with any evaluation of my application, credentials and qualifications,

release from liability all individuals and organizations who provide to Kinnamon Associates, in good faith and without malice, information regarding my professional competence, ethics, and character.

Practitioner:

Signature:

Name:

Professional License Number:

Date:
