LOCATION INFORMATION FORM
Please complete one form for each location

Facility Name_____

Location Address_____

Office Phone _____ Office Fax _____

Office Contact Name_____ Title _____

Office Hours (example 8-5): Mon._____ Tues._____ Wed._____

Thur._____ Fri._____ Sat._____ Sun._____

Check One: Solo Practice_____ Group Practice/ Number of Doctors_____

Please List Names of All Doctors Practicing at this Location: _____

_____

Building Liability Insurance Carrier: _____ Expiration Date_____

Office Size (in sq. feet): _____ # of Treatment Tables: _____

Number of Examination Rooms: _____

Georgia X-Ray Certification (Yes/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 & _____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 & 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: _____

_____