

## LOCATION INFORMATION FORM

**\*\*\*Please complete one form for each location\*\*\***

Location Address

Office Phone

Office Fax

Office Contact Name

Title

Check One: Solo Practice

Group Practice/ Number of Doctors

Please List Names of All Doctors Practicing at this Location:

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: