Behavioral Care Partners Provider Network Screening Form

Complete form and fax to: 630-646-5477 Attn: Provider Relations

Provider Name & Credentials/Licenses:	□Male □Female
Provider Agency/Practice Name:	
Office Locations of Provider's Practice:	
Office Days/Hours:	
Client Age Range:	
Languages Spoken:	

Please indicate all that apply to your individual practice:

	Family Therapy		Anxiety		LGBTQ		Sensory Integration
	Group Therapy		Autism Spectrum Disorders		Men's Issues		Sexual Dysfunction
	ACT		Bi-Polar Disorder		OCD		Spiritual Counseling
	Art Therapy		Co-Dependency		Pain/Chronic Pain Management		Stress Management
	Biofeedback		Depression		Personality Disorders		Women's Issues
	CBT		Domestic Violence		Phobias		Addictions:
	Critical Incident Debriefing		Dual Diagnosis		Post-Partum Depression		Alcohol
	DBT		Eating Disorders		PTSD		Drug
	EMDR		Ethnic/Cultural Issues: _____		Psychotic Disorders		Food
	Play Therapy		Grief and Loss		Reactive Attachment Disorder		Gambling
	Solution Focused Treatment		Illness/Medical Issues		Religious/Faith-Based: _____		Internet
	ADD/ADHD		Infertility		School Issues / Truancy		Pornography
	Anger Management		Intervention Services		Self-Injury		Sex
	Sexual Assault/Abuse		Gender Identity/ Transgender		Exposure Therapy		

Group Therapy (type of group, age range, dates and times offered):
Other areas of clinical interest/specialty:
Clinical Treatment Philosophy: