



Behavioral Health Addendum

Instructions: This Behavioral Health Addendum must be completed in its entirety for any Behavioral Health agreement.

Date Completed:		Name:		
Individual NPI:		Group NPI:	Tax ID:	
Do you provide services to the following populations? (Check all that apply)				
<input type="checkbox"/> Serious Mental Illness (SMI)		<input type="checkbox"/> Serious Emotional Disturbance (SED)		
<input type="checkbox"/> Severe Persistent Mentally Ill (SPMI)				
Are you able to provide services to any of the following special needs populations? (Check all that apply)				
<input type="checkbox"/> Deaf/Hearing Impaired		<input type="checkbox"/> Blind/Vision Impaired		
<input type="checkbox"/> Developmental Disability		<input type="checkbox"/> Physical Disability		
<input type="checkbox"/> Other _____				
Are the following areas in your office ADA Compliant? (Check all that apply)				
<input type="checkbox"/> Building	<input type="checkbox"/> Bathroom(s)	<input type="checkbox"/> Therapy Room(s)	<input type="checkbox"/> Parking	<input type="checkbox"/> Equipment
Please select the types of services you offer. (Check all that apply)				
Types of Services				
<input type="checkbox"/> Behavioral Management Services		<input type="checkbox"/> Individual Therapy		
<input type="checkbox"/> Couples Therapy		<input type="checkbox"/> Intensive Outpatient Program (IOP)		
<input type="checkbox"/> Family Therapy		<input type="checkbox"/> Neuropsychological Testing		
<input type="checkbox"/> Group Therapy		<input type="checkbox"/> Psychological Testing		
<input type="checkbox"/> Other (please specify)		<input type="checkbox"/> Other (please specify):		

Please select the types of disorders you treat and the modalities you practice. (Check all that apply)	
Treatment Modalities/Approaches	Disorders/Issues
<input type="checkbox"/> ABA (Applied Behavior Analysis)	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Adjustment Disorders
<input type="checkbox"/> Client Centered Therapy	<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Attachment Disorders
<input type="checkbox"/> Dialectical Behavioral Therapy	<input type="checkbox"/> Autism Spectrum
<input type="checkbox"/> EMDR	<input type="checkbox"/> Dissociative Disorders
<input type="checkbox"/> Family Systems	<input type="checkbox"/> Disruptive Behavior Disorders
<input type="checkbox"/> Gestalt	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Impulse Control Disorders
<input type="checkbox"/> Methadone/Suboxone Medication Services	<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Neuro-Linguistic Programming (NLP)	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Psychoanalytic	<input type="checkbox"/> PTSD
<input type="checkbox"/> Rationale Emotive Therapy	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Solution Focused Therapy	<input type="checkbox"/> Substance Abuse/Dependence Disorders
<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Sexual Abuse (Children)
<input type="checkbox"/> Trauma Focused -CBT	<input type="checkbox"/> Sexual Abuse (Adults)
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Sexual Disorders
	<input type="checkbox"/> Other (please specify):