PREFERRED THERAPY PROVIDERS

NEW THERAPIST APPLICATION

CLINIC NAME ____________________

TAX ID # ____________________

LICENSED THERAPISTS — Note: PREFERRED does not credential PTAs, OTAs or SLPAs

PT	OT	SLP	ABA	CHT	NAME	NPI #	CAQH ID #*	CERTIFICATION #

*If registered with CAQH, please ensure you have granted PREFERRED Therapy Providers authorization to review and obtain your data.

Completion of the release form below is required for each therapist. Please submit one release per therapist.

RELEASE OF INFORMATION: I authorize Preferred Therapy Providers, Inc and/or its delegated agents to consult with and obtain from any and all individuals and organizations who can provide information concerning my professional liability coverage and claims, information bearing on my professional competence, ability to perform appropriate services and procedures, character, ethical qualifications and ability to work cooperatively with others. I release from liability and hold harmless both those individuals and organizations who have provided this information and Preferred Therapy Providers, Inc and its delegated agents in using this information. I understand I have the burden of producing adequate information for a proper evaluation or reevaluation of my professional, ethical and other qualifications. I acknowledge that any significant misstatement in, or omission of, information provided may result in the termination of my relationship with Preferred Therapy Providers, Inc.

____________________ ____________________

THERAPIST PRINT NAME **DATE**

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THERAPIST SIGNATURE

23460 N 19th Ave. Ste.250 Phoenix, AZ 85027
800-664-5240 Fax: 623-869-9102