New Client Questionnaire~

Please complete all pages. Thank you!

Bulldog Billing

Medical Contracts, Credentialing, Claims, Consulting

DATE:_____ **PROVIDER NAME:**_____

DATE OF BIRTH:_____ **CELL PHONE #:**_____

GROUP/ PRACTICE NAME:_____ **TAX ID#:**_____

PRACTICE SPECIALTY:_____

DOCUMENTS NEEDED: (Please complete all applicable information & provide all documents)

- _____NPI NUMBER _____ TYPE II NPI (groups):_____
  User ID: _____ PW: _____ Used to register for NPI number
- _____Are you registered w/ CAQH? I will be doing all updates/attestations during the credentialing process.
  If so, CAQH#: _____ User ID: _____ PW: _____
- _____CA STATE PROVIDER LICENSE (Orig.Issue. Date:_____, Current Exp: _____)
- _____ DEA LICENSE (if applicable) (send copy) _____ COPY OF DIPLOMA (highest degree) (provide copy of license)
- _____SOCIAL SECURITY #_____ FORMER/ MAIDEN NAME:_____
- _____BIRTH CITY:_____STATE:_____COUNTRY:_____
- _____NON-ENGLISH LANGUAGES SPOKEN FLUENTLY:_____
- _____CDL &/or PASSPORT (send copy) _____PROFESSIONAL HEADSHOT
- _____W-9 (Please just sign this~ I'll complete) _____BIO (~2 paragraphs)
- _____ARTICLES OF INCORPORATION (if applicable)
- _____FICTITIOUS NAME PERMIT _____OFFICE LEASE AGREEMENT (must have your name & all signatures on it)
- _____CITY BUSINESS LICENSE
- _____IRS LETTER (SS-4) TAX ID/ EIN NOTICE (send copy of original)
- _____UP TO DATE CURRICULUM VITAE (to incl 5 years of employment; dates in mm/yy format)
  Any gaps employment/ education >3 months? If so, please attach explanation. (send copy)
- _____BUSINESS CHECKING ACCOUNT? (Attach a VOIDED PRE-PRINTED CHECK)
  Branch Address/Phone Where Acct Opened at:_____
  _____
- _____MALPRACTICE INSURANCE (**$1M/$3M—Required Limits**) (send copy)
- _____PROPERTY LIABILITY INSURANCE (MUST have Business Name/Address on it)

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Do you give me permission to create a Digital ID Signature & Credentialing Email to use as needed for the SOLE purpose of submitting applications to the requested Insurance Companies? ☐ **YES** ☐ **NO**

INSURANCE COMPANIES TO CREDENTIAL WITH: (Please check those that you are interested in credentialing/ contracting with)

- _____ AETNA
- _____ ANTHEM/ BLUE CROSS
- _____ BLUE SHIELD
- _____ CIGNA
- _____ HEALTHNET
- _____ MAGELLAN (MH Carve-Out for Blue Shield) **80% of BShield plans...
- _____ CAL OPTIMA(MH Carve-Out for Orange Cnty Medi-Cal) ***Must do Medi-Cal also***
- _____ MEDI-CAL (In conjunction with Cal-Optima or separately as c/o to Medicare)
- _____ MEDICARE (Does not credential LMFT's)
- _____ MHN (MH Carve-Out for Healthnet)
- _____ TRICARE
- _____ OPTUM HEALTH (incl Oscar & UMR)
- _____ UNITED HEALTH CARE
- _____ KAISER PERMANENTE (included w/
- _____ BEACON HEALTH/ VALUE OPTIONS
- _____ BEACON HEALTH STRATEGIES (Medi-Cal)
- _____ OTHER _____
- _____ HMC HEALTHWORKS
- _____ MOLINA HEALTHCARE
- _____ HMSA (Hawaii)
- _____ OTHER_____

***DISCLAIMER: Some panels could be closed for new providers. I cannot provide a guarantee of inclusion, only an educated, researched opinion for you in helping you make your decisions. Unfortunately, this also includes the total length of time from beginning to Executed In-Network Contract Status.*

DO YOU HAVE ANY ADDITIONAL CERTIFICATIONS THAT WOULD BE APPLICABLE? IF SO, PLEASE PROVIDE A COPY OF THOSE CERTIFICATIONS ALONG WITH YOUR OTHER PAPERWORK.

FILING STATUS: If you are the TIN owner will you be filing taxes using.....

☐ Form 1120? (Sole Owner) ~Requires NPI Type I & II~ Form

☐ 1040C? (Sole Proprietor) ~Requires NPI Type I Only~

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All insurances want a practice profile to be included with their applications- which means you must have a business location. **Do you have a Practice location already?** ☐ YES ☐ NO

EMERGENCY RESPONDERS for your Practice: ◯ Military/ Federal

◯ Emergency Responder (this choice will allow eligible providers to meet various needs during state of emergency, specifically removing the requirement for a current license for each state in which you practice)

REGISTERED ASSISTANTS/ INTERNS/ EXTERNS

- Are you registered with the appropriate governing Board under the Licensed Professional? ◯ Y ◯ N
- Registration #:_____ (Please include proof of this with your documents)
- Do you have an NPI #? ◯ Y ◯ N~~ What is it?_____ Must include the Practice you're registered at and providing services for.

- EAP (Employee Assistance Programs)~ Are you interested in seeing EAP patients? ☐ YES ☐ NO
  If so, please complete the EAP Questionnaire
- Will you be available to provide **routine care** within 10 business days of request?..... ☐ YES ☐ NO
- Will you be available to provide **urgent care** within 48 hours?..... ☐ YES ☐ NO
- Will you be available to provide **emergency care** within 6 hours?..... ☐ YES ☐ NO

EMAIL ADDRESSES: ****VERY IMPORTANT**** There will be many instances when you will receive emails that I will need you to forward to me right away AS they are TIME SENSITIVE!

Please provide the **BEST EMAIL** for this situation:_____

Additionally, if you have a **PROFESSIONAL** email that you use for patients, please provide that here:_____

*The information I've asked for here is **REQUIRED** (unless otherwise noted). It's a requirement when creating the CAQH, it's a requirement for most insurance applications and it's a requirement for Medicare & Medi-Cal. Any insurance that you're going through the credentialing & contracting process with will need to confirm & verify that the information provided to them is in alignment with the CAQH, including (but not limited to) your SSN, State License, your Licensing Board & your CA Drivers License. I'm sorry, I don't ask for any information unless it's truly needed. Please be assured that all communication devices used by Bulldog Billing are completely secure and encrypted with a 2-layer verification system for your security and privacy. Your information will never be used for any purpose other than what you've agreed to & intended.*

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Practice Name (as registered): _____

Practice Address/Service Location: _____

_____

Business Phone (for patients): _____

Mailing Address: _____

_____

_____

I'll need your home address:

Home Address: _____

(if different from mailing) _____

_____

Contact Phone #: _____

Email Address: _____

DOB: _____

Please explain any gaps of employment within the last 5 years of >3 months: _____

_____

_____

_____

Please note that future address changes would be happily made with all of your contracted insurance companies. However, there will be an additional fee charged of $350. Thank you for your understanding!

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Your signature below (hand signed or typed) allows Bulldog Billing to use all information contained in this, and all additional submitted documents, for the express use of Credentialing/ Contracting & Insurance Billing for Provider &/or Group as discussed & agreed upon.

Provider/ Title

Date

Please provide your hand-signed signature below in the box for me to use as the template for the digital one (**stay inside the borders**).

Disclaimer~

Please be advised that there may be tasks that you ask of me that are not included in the fees that you have paid to me. If this occurs, I will advise you that you'd be charged my hourly rate for those services.

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CHECKLIST for NEEDED DOCUMENTS

- ◯ State Provider License
- ◯ Diploma (highest degree)
- ◯ DEA License
- ◯ Social Security Card
- ◯ Drivers License
- ◯ W-9
- ◯ Biography (~2 paragraphs)
- ◯ Tax ID Notice from IRS
- ◯ Articles of Incorporation
- ◯ Fictitious Name Permit
- ◯ City Business License
- ◯ Office Lease Agreement
- ◯ CV/ Resume
- ◯ Voided Business Check
- ◯ Malpractice Insurance
- ◯ _____

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COMPLETE THIS ENTIRE PAGE PLEASE

PROVIDER NAME:_____ DATE:_____

LANGUAGES YOU CAN TREAT IN FLUENTLY: _____

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ ASL (American Sign Language)

Do you provide services via.....

☐ **TELEHEALTH** ☐ **IN PERSON** ☐ **BOTH**

PROVIDERS ETHNICITY:_____

DO YOU HAVE LIMITATIONS IN YOUR PRACTICE?

_____

_____

WHAT IS YOUR PRACTICE PROFILE FOCUS?

_____

_____

_____

****BEHAVIORAL HEALTH SPECIALTIES**** (check all that apply)

☐ ADD/ADHD	☐ DIALECTIC BEHAVIORAL THERAPY-DBT	☐ NEUROPSYCH TESTING
☐ ADJUSTMENT TO ILLNESS/DISABILITY	☐ DISSOCIATIVE DISORDERS	☐ OBSESSIVE-COMPULSIVE-OCD
☐ ADOPTION	☐ DOMESTIC VIOLENCE	☐ OCCUPATIONAL ISSUES
☐ ANGER MANAGEMENT	☐ DUAL DIAGNOSIS	☐ OUTPATIENT DETOXIFICATION
☐ ANXIETY	☐ EATING DISORDERS	☐ PAIN MANAGEMENT
☐ APPLIED BEHAVIORAL ANALISIS-ABA	☐ EMDR	☐ PARENTING ISSUES
☐ AUTISM SPECTRUM DISORDER	☐ FAMILY THERAPY	☐ PERSONALITY DISORDERS
☐ BIOFEEDBACK	☐ GAMBLING	☐ PHARMACOLOGY-MED MGMT
☐ BIPOLAR	☐ GAY-LESBIAN	☐ PLAY THERAPY
☐ CERTIFIED EAP	☐ GENDER IDENTITY	☐ POST TRAUMATIC STRESS-PTSD
☐ CHEMICAL DEPENDENCY	☐ GERIATRIC PSYCHIATRY	☐ PSYCHOLOGICAL TESTING
☐ CHILD ABUSE	☐ GRIEF COUNSELING	☐ PSYCHOTIC DISORDERS
☐ CHRISTIAN COUNSELING	☐ GROUP THERAPY	☐ SAP
☐ CHRONIC PAIN	☐ HEARING IMPAIRED	☐ SELF MUTILATION
☐ CISD	☐ HIV/AIDS	☐ SEXUAL ADDICTION
☐ CODEPENDENCY	☐ HYPNOTHERAPY	☐ SEXUAL DYSFUNCTION
☐ COGNITIVE BEHAVIORAL THERAPY-CBT	☐ IN HOME THERAPY	☐ SEXUAL-PHYSICAL ABUSE
☐ COMORBIDITY	☐ LEARNING DISABILITIES	☐ STRESS MANAGEMENT
☐ COUPLES COUNSELING	☐ LIFE MANAGEMENT COUNSELING	☐ TERMINAL ILLNESS
☐ CRISIS INTERVENTION	☐ MANAGED DISABILITY	☐ TRAUMATIC BRAIN INJURY-TBI
☐ CULTURAL DIVERSITY	☐ MEN'S ISSUES	☐ WOMEN'S ISSUES
☐ DEPRESSION	☐ MOOD DISORDERS	☐ MINDFULNESS THERAPY

CULTURALLY DIVERSE SPECIALITIES:_____

AGE PREFERENCE: Put ages for each. _____Child _____ Adolescent _____Adult _____ Geriatric

PRACTICE HOURS: Sun____Mon_____Tues_____Weds_____Thurs_____Fri_____Sat_____

DOES YOUR PRACTICE MEET ALL ADA REQUIREMENTS: **YES**☐ **NO**☐

HOW FAR AWAY IS YOUR PRACTICE FROM PUBLIC TRANSPORTATION:_____ miles/ block

HAVE YOU COMPLETED CULTURAL COMPETENCY TRAINING? YES☐ **NO**☐

DO YOU HAVE HOSPITALS AFFILIATIONS? YES☐ **NO**☐ **NAME/CITY of**

HOSP:_____ **DO YOU HAVE AN ARRANGEMENT WITH A PROVIDER FOR A**☐**ITTIN**☐

YOUR PATIENTS? YES____ NO____ **IF SO, PLEASE GIVE**

DETAILS:_____

Please SIGN only---- do NOT put a date on it---- I'll complete the UPPER section

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

PRACTICE/ PROVIDER BIOGRAPHY....

Please provide details on your practice; including any pertinent information about the services you offer or clients served to assist in determining eligibility for an exception. What makes you as a provider different from others in your field/ area?

BUSINESS ASSOCIATE AGREEMENT (HIPAA)

This Privacy Agreement ("Agreement"), is effective upon signing this Agreement and is entered into by and between BULLDOG BILLING ("Covered Entity") and _____ (the "Business Associate").

I. Term. This Agreement shall remain in effect for the duration of this Agreement and shall apply to all of the Services and/or Supplies delivered by the Business Associate pursuant to this Agreement.

II. HIPAA Assurances. In the event Business Associate creates, receives, maintains, or otherwise is exposed to personally identifiable or aggregate patient or other medical information defined as Protected Health Information ("PHI") in the Health Insurance Portability and Accountability Act of 1996 or its relevant regulations ("HIPAA") and otherwise meets the definition of Business Associate as defined in the HIPAA Privacy Standards (45 CFR Parts 160 and 164), Business Associate shall:

(a) Recognize that HITECH (the Health Information Technology for Economic and Clinical Health Act of 2009) and the regulations thereunder (including 45 C.F.R. Sections 164.308, 164.310, 164.312, and 164.316), apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity;
(b) Not use or further disclose the PHI, except as permitted by law;
(c) Not use or further disclose the PHI in a manner that had the Covered Entity done so, would violate the requirements of HIPAA;
(d) Use appropriate safeguards (including implementing administrative, physical, and technical safeguards for electronic PHI) to protect the confidentiality, integrity, and availability of and to prevent the use or disclosure of the PHI other than as provided for by this Agreement;
(e) Comply with each applicable requirements of 45 C.F.R. Part 162 if the Business Associate conducts Standard Transactions for or on behalf of the Covered Entity;
(f) Report promptly to the Covered Entity any security incident or other use or disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware;
(g) Ensure that any subcontractors or agents who receive or are exposed to PHI (whether in electronic or other format) are explained the Business Associate obligations under this paragraph and agree to the same restrictions and conditions;
(h) Make available PHI in accordance with the individual's rights as required under the HIPAA regulations;
(i) Account for PHI disclosures for up to the past six (6) years as requested by Covered Entity, which shall include: (i) dates of disclosure, (ii) names of the

entities or persons who received the PHI, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose and basis of such disclosure;
(j) Make its internal practices, books, and records that relate to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for purposes of determining Customer's compliance with HIPAA; and
(k) Incorporate any amendments or corrections to PHI when notified by Customer or enter into a Business Associate Agreement or other necessary Agreements to comply with HIPAA.

III. Termination Upon Breach of Provisions. Notwithstanding any other provision of this Agreement, Covered Entity may immediately terminate this Agreement if it determines that Business Associate breaches any term in this Agreement. Alternatively, Covered Entity may give written notice to Business Associate in the event of a breach and give Business Associate five (5) business days to cure such breach. Covered Entity shall also have the option to immediately stop all further disclosures of PHI to Business Associate if Covered Entity reasonably determines that Business Associate has breached its obligations under this Agreement. In the event that termination of this Agreement and the Agreement is not feasible, Business Associate hereby acknowledges that the Covered Entity shall be required to report the breach to the Secretary of the U.S. Department of Health and Human Services, notwithstanding any other provision of this Agreement or Agreement to the contrary.

IV. Return or Destruction of Protected Health Information upon Termination. Upon the termination of this Agreement, unless otherwise directed by Covered Entity, Business Associate shall either return or destroy all PHI received from the Covered Entity or created or received by Business Associate on behalf of the Covered Entity in which Business Associate maintains in any form. Business Associate shall not retain any copies of such PHI. Notwithstanding the foregoing, in the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible upon termination of this Agreement, Business Associate shall provide to Covered Entity notification of the condition that makes return or destruction infeasible. To the extent that it is not feasible for Business Associate to return or destroy such PHI, the terms and provisions of this Agreement shall survive such termination or expiration and such PHI shall be used or disclosed solely as permitted by law for so long as Business Associate maintains such Protected Health Information.

V. No Third Party Beneficiaries. The parties agree that the terms of this Agreement shall apply only to themselves and are not for the benefit of any third party beneficiaries.

VI. De-Identified Data. Notwithstanding the provisions of this Agreement, Business Associate and its subcontractors may disclose non-personally identifiable information provided that the disclosed information does not include a key or other mechanism that would enable the information to be identified.

VII. Amendment. Business Associate and Covered Entity agree to amend this Agreement to the extent necessary to allow either party to comply with the Privacy

Standards, the Standards for Electronic Transactions, the Security Standards, or other relevant state or federal laws or regulations created or amended to protect the privacy of patient information. All such amendments shall be made in a writing signed by both parties.

VIII. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the then most current version of HIPAA and the HIPAA privacy regulations.

IX. Definitions. Capitalized terms used in this Agreement shall have the meanings assigned to them as outlined in HIPAA and its related regulations.

X. Survival. The obligations imposed by this Agreement shall survive any expiration or termination of this Agreement.

COVERED ENTITY

Signature _____ Date 10/7/2022

Print Name VERONICA BUSH Title: OWNER/ PRESIDENT

BUSINESS ASSOCIATE

Signature _____ Date _____

Print Name _____ Title: _____