



Complete this form to disclose the most current information regarding your areas of expertise. This information will be made available to members to aid them in accessing appropriate care. A separate profile form must be completed for each individual provider. Please make copies of the form as applicable.

PROVIDER INFORMATION

Provider Name	Provider Specialty
Provider Tax ID	National Provider Identifier (NPI)
Contact Name	Email Address
Phone Number	Fax Number

PATIENT AGES

Please check the age ranges of the client populations you treat:

- | | | |
|---|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 0 to 5 | <input type="checkbox"/> 6 to 12 | <input type="checkbox"/> 13 to 17 |
| <input type="checkbox"/> 18 to 64 | <input type="checkbox"/> Over 65 | <input type="checkbox"/> All Ages |
| <input type="checkbox"/> Other (<i>please specify</i>): | | |

LANGUAGES

Please check all languages other than English spoken fluently in your office and in which you can provide treatment:

- | | | |
|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> Spanish | <input type="checkbox"/> French | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> German | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Sign Language | | |
| <input type="checkbox"/> Other (<i>please specify</i>): | | |

AREAS OF EXPERTISE

Please check all that pertain to the **types of therapy** you provide:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Behavioral Therapy for Autism | <input type="checkbox"/> Eye Movement Desensitization and Reprocessing (EMDR) | Medications Assisted Treatment (MAT) |
| <input type="checkbox"/> Cognitive Behavioral Therapy (CBT) | <input type="checkbox"/> Family Therapy | |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Group Therapy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Dialectical Behavioral Therapy (DBT) | <input type="checkbox"/> Telehealth | <input type="checkbox"/> Opiates |
| <input type="checkbox"/> Electroconvulsive Therapy (ECT) | | |

Please check all that pertain to the **types of disorders/issues/subspecialties** you provide:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abuse, Assault and Trauma (PTSD) | <input type="checkbox"/> Depression | <input type="checkbox"/> Obsessive Compulsive Disorders |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Divorce/Blended Family Issues | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Anxiety and Panic Disorders | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Attention Deficit Disorders | <input type="checkbox"/> End of Life Issues | <input type="checkbox"/> Postpartum Issues |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Gay/Lesbian/Bisexual Issues | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Bariatric Assessment | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Prenatal Issues |
| <input type="checkbox"/> Behavioral Modification | <input type="checkbox"/> HIV/AIDS Related Issues | <input type="checkbox"/> Schizophrenic Disorders |
| <input type="checkbox"/> Bipolar Disorders/Manic Depression | <input type="checkbox"/> Infertility | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Brief Solution Focused | <input type="checkbox"/> Medication Management | <input type="checkbox"/> Sexual Disorders |
| <input type="checkbox"/> Compulsive Gambling | <input type="checkbox"/> Men's Issues | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Cultural/Ethnic Issues | <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Transgender Issues |

Please complete this form and return via fax to 1-877-212-5640 or email at LouisianaPR@lucethealth.com.