Dear Provider,

Matrix is a group of mental health professionals in the Columbus, Ohio area who specialize in Employee Assistance Programs. We currently serve as providers for several national corporations who have employees in your area.

We at Matrix seek high quality short-term therapy for our clients. Following the completion of their EAP sessions, you would be free to either continue providing services under the terms of their health insurance or at your self-pay rate. You may also refer them to other suitable providers. Our goal is to provide problem resolution by means of goal-oriented therapy within a reasonable time frame. You would be expected to complete only minimal administrative tasks. Since extensive utilization review and cumbersome paperwork have been a principal drawback of managed care, we at Matrix have made an effort to keep these tasks lo an absolute minimum. We will assume all responsibility for all reporting to the client companies and all program marketing.

If you feel you might be interested in seeing our patients please complete the enclosed application and return it to me as soon as possible. We have a need for additional providers in your area. We will accept an application from any licensed mental health provider in your practice. Please duplicate the application form as necessary. Please feel free to contact me to answer any additional questions you may have at 800-886-1171 or view our website for more information at Matrixpsych.com. Our provider paperwork is also available for you to review on our website under "For Providers".

Cordially,

Client Services Managers
Matrix Integrated Psychological Services
Networkstaff@matrixpsych.com

National Headquarters:
Matrix Psychological Services 2 Easton Oval, Suite 450
Columbus, OH 43219
P: 614.475.9500 || T: 800.886.1171 || F: 614.475.9821

MATRIX

EAP Provider Application

Name _____
First Middle Last

DOB: _____ Race (Optional to assist with client preferences): _____

Tax ID#: _____

Date of Active Practice: _____

Professional Licenses: _____ State _____ # _____ Exp. Date _____

Professional Licenses: _____ State _____ # _____ Exp. Date _____

EDUCATION TRAINING

Highest Degree Attained: _____ Year Graduated: _____ Area of Specialization: _____ University Attended: _____

DePt: _____

Internship: _____ Year: _____ APA Approved: ☐ YES ☐ NO

OFFICE ADDRESS

Facility Name: _____

Street Address: _____

City, State, Zip-Code: _____

10-Digit Phone Number: _____

Office Fax Number: _____

Email Address: _____

Mailing Address (if different from location's):_____

Type of Practice

(*CHECK ALL THAT APPLY*)

- ☐ Academic Anxiety
- ☐ ACOC
- ☐ Addictions
- ☐ ADHD/ADD
- ☐ Alcohol/Substance Abuse
- ☐ Anxiety
- ☐ Anger Management
- ☐ Assimilation
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Body Dysmorphia
- ☐ Bullying
- ☐ Career Issues
- ☐ Child Abuse
- ☐ Chronic/Terminal Illness
- ☐ Cutting
- ☐ Depression
- ☐ Divorce
- ☐ Eating Disorders
- ☐ EMDR
- ☐ Family Therapy
- ☐ Family of Origin Issues
- ☐ Gender Identity
- ☐ Geriatric Issues
- ☐ Grief/Loss
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Life Transitions
- ☐ Loneliness
- ☐ Martial/Couples
- ☐ Men's Issues
- ☐ Mood Disorders
- ☐ Multi-Cultural Issues
- ☐ OCD
- ☐ Panic Attacks
- ☐ Parenting Skills
- ☐ Perfectionism
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Postpartum Depression
- ☐ PTSD
- ☐ Queer Issues
- ☐ Racial Identity/Minority Concerns
- ☐ Relationships Issues (individual)
- ☐ Self-Esteem
- ☐ Self-harm
- ☐ Sexual Abuse
- ☐ Sexual Disorders
- ☐ Sexual Orientation
- ☐ Stress Management
- ☐ Spirituality
- ☐ Suicidal Bereavement
- ☐ Suicidal Ideation
- ☐ Psychological Testing
- ☐ Trans Issues
- ☐ Trichotillomania
- ☐ Trauma
- ☐ Rape/Sexual Assault

Age of Clients Seen: _____

Is your business wheelchair accessible? ☐ YES ☐ NO

Have you had training in Cultural Diversity? ☐ YES ☐ NO

If yes, please specify:

_____

_____

_____

Please describe other types of clients seen that are not on the above checklist:

_____

_____

_____

_____

_____

_____

Areas or Types of clients your prefer not to see:

_____

_____

_____

_____

What arrangements do you and your office have for 24-Hour, 7-Day Coverage for emergencies? (*i.e*. – if a current client needs to get in touch with you or another provider during an emergency, do you make sure that they know the procedure? What is that procedure? Do you have an answering service ex. Answering machine that is checked on a regular basis? Or a 24-Hour cell phone/pager?):

_____
_____
_____
_____
_____
_____
_____
_____

Please list any additional languages of fluency:

_____
_____

Please list your hours of Operation:

Monday_____ Tuesday_____ Wednesday _____ Thursday_____

Friday_____ Saturday_____ Sunday _____

Would you be comfortable seeing clients who have been mandated by their employer? A signed release would be in place authorizing communication with the client's HR/supervisor. ☐ YES ☐ NO

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Medical Malpractice/liability

Please attach a copy of your malpractice insurance certificate

_____,_____ _____

Malpractice amount per Occurrence /per year Exp. Date

1. Have you ever been or are you currently a party to charges of malpractice, or are you aware of any incident or existing circumstances that might reasonably lead to such a claim? ☐ YES ☐ NO

2. Has your license to practice ever been denied, restricted, limited, suspended, or revoked, or have you been reprimanded by a licensing agency? ☐ YES ☐ NO

3. Have any complaints been filed against you? ☐ YES ☐ NO

4. Are you now being treated for alcoholism or drug addiction? ☐ YES ☐ NO

5. Have you ever been charged with a felony or misdemeanor, other than a simple traffic violation? ☐ YES ☐ NO

6. Have you ever been or are you now under investigation by a regulatory agency (e.g. Medicare, state health department)? ☐ YES ☐ NO

7. Have you ever been accused of sexual misconduct or any professional impropriety? ☐ YES ☐ NO

8. Do you know of any reason why you or any of your employees cannot comply with the legal, ethical, or professional standards set by law, regulation, a peer review committee, or an applicable code of ethics in any jurisdiction where you provide services? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE ATTACH EXPLANATION.

From time to time Matrix is asked to send a psychologist to an employer's site for counseling regarding issues such as difficult terminations, death of a co-worker, etc. Would you like to be contacted for such referrals? ☐ YES ☐ NO

If yes, please briefly describe your experience in this area:

_____

_____

_____

_____

_____

_____

_____

Please indicate what forms of, therapy you are currently offering:

Telehealth (video)☐ Telehealth (telephonic)☐ In-person☐

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I hereby certify that all statements made in the above application are true.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness Signature: _____ Date: _____

Print Name: _____ Date: _____

** Please attach copies of your Curriculum Vitae, Certificate of Insurance, Professional License and Diploma **

Please Fax, Mail, or Email your completed application to:

Matrix Psychological Services 2 Easton Oval, Suite 450

Columbus, OH 43219

P: 614.475.9500 || T: 800.886.1171 || F: 614.475.9821

| www.matrix.psych.com |

| Networkstaff@matrixpsych.com |

Below is a checklist for required items. Please be sure that all of the required items are enclosed before returning application.

Thank you.

- ☐ Completed Application.
- ☐ Explanation for any malpractice question answered Yes.
- ☐ Witness signature on this page.
- ☐ Current License.
- ☐ Curriculum Vitae.
- ☐ Certificate of Insurance.
- ☐ Diploma.