

Please complete a separate assessment for all Primary Care Physicians, Psychiatrists, or Dentists at this practice site.
If a provider practices as multiple locations, please fill out a separate survey for each additional location.

A. Provider Information											
Provider Name:											
	<i>(First)</i>			<i>(Middle)</i>			<i>(Last)</i>				
TX Medical/ Dental License #:				NPI #:				Discipline: (choose one)			
								<input type="checkbox"/> Primary Care	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Dentistry	
Specialty: (choose one)	Primary Care:			Psychiatry:			Sub-specialty (if applicable):				
	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Psychology	<input type="checkbox"/> Ped Nurse Spec	<input type="checkbox"/> Marriage/Family	<input type="checkbox"/> Clinical Social Work			
	Dentistry:		<input type="checkbox"/> General/Pediatric	<input type="checkbox"/> Clinical Psychology				% of Practice:	_____ %		
Practice Physical Address:											
Practice City:				State:			Zip Code:			County:	
Phone Number:			Office email:				Practice Type:				
Fax Number:			Provider email:				<input type="checkbox"/> Private/Group	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Correctional	<input type="checkbox"/> State/County Mental Hospital	
							<input type="checkbox"/> Other:				
B. Provider Direct Care Hours per Week											
1a. How many hours per week does physician provide <u>Direct Outpatient</u> care* (not to exceed 40 hours)? _____ hours											
<i>*This is direct care by the physician ONLY, including face-to-face time seeing patients in office, interpreting lab results, and consultations with other physicians. Do not include administrative hours, teaching/education/research hours, or inpatient hours (if also practicing at a hospital).</i>											
1b. For Dentists: How many Auxiliaries does the provider have? <input type="checkbox"/> Assistants _____ <input type="checkbox"/> Hygienists _____											
C. Patient Categories (Please provide closest estimate if exact percentage unknown. If a specific category is not applicable to your practice, please enter "0" or "N/A.")											
2. What percentage of your patients have Medicaid coverage? _____ %					4. What percentage of patients are comprised of these special categories?						
3. What percentage of your patients use the Sliding Fee Scale (SFS)**? _____ %					Homeless: _____ %		Native American: _____ %		Migrant FW: _____ %		
					Seasonal MFW: _____ %						
<i>** A SFS is a formal discount policy based on income & family size or ability to pay (does not include bad debt write-offs). The SFS must be visibly posted and available to all patients.</i>											
D. Patient Visits (Please provide closest estimate if exact percentage unknown.)											
5. Is physician accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No					8. Average wait time (days) for routine/non-urgent appointment? _____ days						
6. Average # of patients seen in a week? _____ /wk					New Patient		Established Patient				
7. Average # of outpatient visits per year? _____ /yr					_____ mins		_____ mins				
9. Average wait time (minutes) once patients arrive in the office? _____ mins											
E. Physician Status Information											
10. Do any of the special categories below apply?					11. Within the next year, will the provider's status/location change? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> National Health Services Corp	<input type="checkbox"/> Resident/Intern				<input type="checkbox"/> Retiring	<input type="checkbox"/> Moving to different practice					
<input type="checkbox"/> J-1 Visa Holder	<input type="checkbox"/> Federal Provider				<input type="checkbox"/> Decreasing hours	<input type="checkbox"/> Moving out of state					
<input type="checkbox"/> H-1B Visa Holder	<input type="checkbox"/> State Loan Repayment				<input type="checkbox"/> Increasing hours						
<input type="checkbox"/> Locum Tenens	<input type="checkbox"/> Restricted License				<input type="checkbox"/> Other:						
<input type="checkbox"/> Hospitalist: _____ %	<input type="checkbox"/> Instructor: _____ %										
Comment(s):											
Completed by:					Title:						

Please return to Texas Primary Care Office via fax: 512-776-7203 or email: TexasPCO@dshs.state.tx.us

Questions: Please call the TPCO at (512) 776-7518.