

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

A. Provider Information									
<b>Provider Name:</b>									
	<i>(First)</i>			<i>(Middle)</i>			<i>(Last)</i>		
<b>TX Medical/ Dental License #:</b>				<b>NPI #:</b>				<b>Discipline: (choose one)</b>	
								<input type="checkbox"/> Primary Care <input type="checkbox"/> Psychiatry <input type="checkbox"/> Dentistry	
<b>Specialty: (choose one)</b>	<b>Primary Care:</b>			<b>Psychiatry:</b>			<b>Sub-specialty (if applicable):</b>		
	<input type="checkbox"/> Family Practice		<input type="checkbox"/> Internal Medicine		<input type="checkbox"/> Psychology		<input type="checkbox"/> Ped Nurse Spec		
	<input type="checkbox"/> OB/GYN		<input type="checkbox"/> Pediatrics		<input type="checkbox"/> Marriage/Family		<input type="checkbox"/> Clinical Social Work		
<b>Dentistry:</b>		<input type="checkbox"/> General/Pediatric		<input type="checkbox"/> Clinical Psychology		<b>% of Practice:</b>		%	
<b>Practice Physical Address:</b>							Does provider practice at multiple sites? <input type="checkbox"/> Yes* <input type="checkbox"/> No <i>If yes, complete an assessment for each site.</i>		
<b>Practice City:</b>				<b>State:</b>			<b>Zip Code:</b>		
<b>Phone Number:</b>				<b>Office email:</b>				<b>Practice Type:</b>	
<b>Fax Number:</b>				<b>Provider email:</b>				<input type="checkbox"/> Private/Group <input type="checkbox"/> Urgent Care <input type="checkbox"/> Correctional <input type="checkbox"/> State/County <input type="checkbox"/> Other: <input type="checkbox"/> Mental Hospital	
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) at this site? _____ 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 &amp; 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					<i>New Patient</i>		<i>Established Patient</i>		
6. Average # of patients seen in a week? _____ /wk					8. Average wait time (days) for routine/non-urgent appointment? _____ days		_____ days		
7. Average # of outpatient visits per year? _____ /yr					9. Average wait time (minutes) once patients arrive in the office? _____ mins		_____ 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 Waiver 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: _____ Date: _____									