LAKES CENTER
mental health network

CLINICIAN ONBOARDING FORM

Personal Information

Name: _____ DOB: _____

SSN: _____ Gender (M / F / Other): _____ Marital Status: _____

Address: _____ City: _____ Zip Code: _____

Mobile: _____ Home: _____ Work: _____

Preferred Phone Number: _____ Texting available? ☐ YES ☐ NO

Which direct patient contact number do you want on your business card? _____

Current Email Address: _____
(We will create a first initial and last name @lakescenter.com email address for you.)

Do you want your lakescenter.com email address on your business card? ☐ YES ☐ NO

Your Licenses / Certifications: _____

_____

Preferences

Availability in Office: Please check **N** (Now) for blocks you will be available starting initially onward and **F** (Future) for the times you hope/plan to add.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F
Afternoon	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F
Evening	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F	☐ N ☐ F

Additional Availability Comments: _____

_____

_____

We will be entering patients' data in TherapyNotes and checking benefits. Would you prefer to schedule the actual appointment date/time yourself, or have open times for new referrals in your schedule?

_____

If you are going to contact the patient to arrange the first appointment, how do you prefer we notify you?

☐ Call ☐ Text ☐ Email Which number / address? _____

Are you able to or interested in providing supervision? ☐ YES ☐ NO

Missed Appointment Charge: $ _____

Preferred Populations

List areas of specific interest so we can match referrals effectively.

_____

_____

_____

Gender Preference (Check all that apply): ☐ Male ☐ Female ☐ Other: _____

Age Group Preference (Check all that apply): ☐ Children < 10 years ☐ Adolescents 10 – 17 years

☐ Young Adults ☐ Adults ☐ Geriatric ☐ All Ages

Do you offer Couples Therapy? ☐ YES ☐ NO Family Therapy? ☐ YES ☐ NO

Do you hope to run any groups at LC? ☐ YES ☐ NO

If YES, what kind? _____

Do you offer any Testing or Court Documents? ☐ YES ☐ NO

If YES, what kind? _____

Do you offer Court Ordered Anger Management Treatment? ☐ YES ☐ NO

Do you offer Dual DX or Substance Abuse Counseling? ☐ YES ☐ NO

Certified? _____

Office Use

Independent Contractor Agreement Signed _____

Current Malpractice Coverage on File _____

Current License on File _____

Current CV / Resume on File _____

Entered in TherapyNotes and Account Info Given _____

Direct Deposit Form _____