

2009 CVMHPA DIRECTORY FORM

The information on this form will be used for the next Conejo Valley Mental Health Professionals Association Directory. Please complete all the information that you want to be published in the directory.

If this is a renewal application, please complete this page even if there are no changes from last year.

Name _____		Title (M.D., Ph.D., Psy.D., M.A., M.S.) _____			License or profession _____	
Business Address _____						
(Street)		(Suite)		(City)		(State) (Zip)
Business Phone _____		Fax _____		E-mail _____		Website _____

Please indicate no more than four specialties that you treat:

- | | |
|--|---|
| <input type="checkbox"/> Abuse/Trauma/PTSD | <input type="checkbox"/> Gay/Lesbian Issues |
| <input type="checkbox"/> Addictions/Substance Abuse | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Health Problems/Chronic Pain |
| <input type="checkbox"/> Anxiety/Panic/OCD | <input type="checkbox"/> Impulse Control/Anger/Violence |
| <input type="checkbox"/> Attention Deficit/Hyperactivity | <input type="checkbox"/> Job Related Concerns |
| <input type="checkbox"/> Autism/Aspergers/Mental Retardation | <input type="checkbox"/> Marital/Premarital/Relationship |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Divorce/Mediation | <input type="checkbox"/> Psychotropic Medication Management |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> School/Behavior/Learning Disorders |
| <input type="checkbox"/> Elder Issues | <input type="checkbox"/> Sexual Problems |

Please indicate no more than three special services you provide:

- | | |
|---|--|
| <input type="checkbox"/> Critical Incident Debriefing | <input type="checkbox"/> Mediation/Custody |
| <input type="checkbox"/> EMDR | <input type="checkbox"/> Psychological/Educational Testing |
| <input type="checkbox"/> Hypnotherapy | <input type="checkbox"/> Religious/Spiritual Counseling |
| <input type="checkbox"/> Life Coaching | _____ Other |

Please indicate the populations that you treat:

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Couples |
| <input type="checkbox"/> Adults | <input type="checkbox"/> Families |
| <input type="checkbox"/> Children | <input type="checkbox"/> Seniors |

Please indicate the insurance and managed care companies with whom you are contracted:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Health Net | <input type="checkbox"/> United Behavioral Health (UBH) |
| <input type="checkbox"/> Anthem/Blue Cross | <input type="checkbox"/> Horizon Behavioral Health | <input type="checkbox"/> Value Options (VBH) |
| <input type="checkbox"/> Beech Street | <input type="checkbox"/> Human Affairs International (HAI) | <input type="checkbox"/> Victims of Crime (VOC) |
| <input type="checkbox"/> Blue Shield | <input type="checkbox"/> Integrated Health Plan | <input type="checkbox"/> Worker's Compensation Fund |
| <input type="checkbox"/> CHAMPUS/TriCare | <input type="checkbox"/> Magellan | _____ Other |
| <input type="checkbox"/> Cigna | <input type="checkbox"/> Managed Health Network (MHN) | _____ Other |
| <input type="checkbox"/> College Health IPA (CHIPA) | <input type="checkbox"/> MediCal | _____ Other |
| <input type="checkbox"/> Community Care Network (CCN) | <input type="checkbox"/> Medicare | _____ Other |
| <input type="checkbox"/> First Health | <input type="checkbox"/> PacifiCare | _____ Other |

Please note any groups that you lead: _____

Please note any languages spoken (other than English): _____

Include this information on the CVMHPA Website _____

Signature _____

Please send completed form to: Sally Olshan
30423 Canwood Street, Suite 233
Agoura Hills, CA 91301
www.cvmhpa.org