



## KIDS' NET

Immediate Healthcare for Kids

Voice: (707) 544-6911 x1013 Fax: (707) 526-2918

### PROVIDER INVOLVEMENT AGREEMENT

As part of my professional response to the need for health care for uninsured children in our community, I am volunteering the services I have checked below for children identified by KIDS' NET.

#### Provider Information

Provider Name: \_\_\_\_\_

Group Name other partners at same location: \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Office Contact Person/Title: \_\_\_\_\_

Do you have bilingual capability in your office? \_\_\_\_\_ If so, please list languages \_\_\_\_\_

Hospital Staff Membership: \_\_\_\_\_

Healthcare Insurance Plan Membership: \_\_\_\_\_

California Medical License Number: \_\_\_\_\_

Professional Liability Insurance Carrier: \_\_\_\_\_

(Please attach a copy of your certificate of insurance)

#### Treatment Component

\_\_\_\_\_ Free office visit(s) per week

\_\_\_\_\_ Free office visit(s) per month

\_\_\_\_\_ I will see \_\_\_\_\_ child/children through the course of their particular illness

\_\_\_\_\_ Complete history & physical exam for diagnostic & referral purposes \_\_\_\_\_ per month

\_\_\_\_\_ Provide a "medical home" for a child or family with chronic medical needs for a school year.

Are there specific days of the week we should not schedule for you? M T W TH F

**May we use your name in "Kids' Net" Publications?**

**Yes \_\_\_ No \_\_\_**

I certify that the above information is true and correct. I agree to notify **KIDS' NET** of changes in my license status, malpractice coverage or hospital privileges.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

**THANK YOU!**