Chiropractic Care of Minnesota, Inc.

Chiropractic Satellite Office Application

(Please photocopy this form and complete for each satellite office.)

1. Name _____ State License # _____
   (as shown on license): Last First Middle (Jr., III, etc.)
2. a. ❑ Individual NPI Number:_____ ***(Required)***
   b. ❑ Organizational NPI Number:_____ ***(Required if W-9 indicates other than***
   c. ❑ Medicare Number:_____ ***Individual/Sole Proprietor)***
3. a. Satellite Office Address: (List the address where patients/clients will be treated.)
   Clinic/Practice Name **(required)**:_____
   Street:_____Suite #_____
   City_____ County _____State_____Zip Code (+4)_____ -____
   Day Phone # ( ) _____ Fax? ❑ Yes ❑ No Fax # ( )_____
   b. Do you submit claims electronically? ***(Required in MN)*** ❑ Yes ❑ No
   c. Do you have any partners/associates at this location? ❑ Yes ❑ No
   d. If you answered, "Yes" above, please list your partners/associates below:

Last Name	First Name	Middle Initial	Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Please indicate nearest cross streets:_____
5. Effective Date_____/_____/_____
   Month Day Year
6. Tax Identification # _____ Name Assigned to Tax ID #_____
7. Billing Address: (Where payment is to be sent, if different than Satellite office address)
   Street_____Suite #_____
   City_____ County _____State_____Zip Code (+4)_____ -____
8. Is your office located in a a. ❑ Commercially zoned building b. ❑ Home
   c. ❑ Gym/health spa/salon d. ❑ No office, I travel to clients

   Home office, gym, health spa, or salon only --
   Does the facility charge a fee in order to access chiropractic services? e. ❑ Yes ❑ No
   Do you have a separate room dedicated solely to providing chiropractic services? f. ❑ Yes ❑ No
   If you indicated "home", please answer the following:
   Do patients have to walk through any part of the living quarters? g. ❑ Yes ❑ No
   Is there a separate office entrance with signage? h. ❑ Yes ❑ No
9. Check all communication services available outside of normal business hours to direct patients in an emergency situation.
   ❑After hrs. phone # ( )_____ ❑Cell # ( )_____ ❑Answering service
   ❑Answering machine ❑No after hours service
10. Please indicate the hours you are available to see patients each day.

	Mon. (From/To)	Tues. (From/To)	Wed. (From/To)	Thurs. (From/To)	Fri. (From/To)	Sat. (From/To)	Sun. (From /To)
	_____	_____	_____	_____	_____	_____	_____
Total hrs.	_____	_____	_____	_____	_____	_____	_____

11. Average number of patients/clients you see daily at this location: _____
12. Indicate the number of staff members (other than yourself) who are available to assist with checking patients in and/or patient care (e.g., check on patients, change face paper, place patients on tables, assist patients with equipment, apply or remove physiotherapy): _____
13. Indicate the number of: a. private treatment/exam rooms: _____ b. open bay: _____
14. Please check any of the following areas that are accessible to disabled persons:
    ❑ Office and treatment rooms ❑ Rest rooms ❑ Parking
15. Do you have x-ray equipment in your satellite office? ❑ Yes ❑ No
16. Please list all languages you and/or your staff speak fluently_____

Signature_____ **Date**_____