

PREPARE

NUCC Grouping:	Behavioral Health & Social Service Providers	Practice Setting:	Inpatient/Outpatient or Outpatient Only
Provider Type:	Applied Behavioral Analyst		
Primary Practice State:	FL		
Other Practice State(s):			

PERSONAL INFORMATION**Name**

First Name : **Lacey** Middle Name :
 Last Name : **Miller** Suffix :
 Have you used other names? **No**

Home Address

Street 1 :	8408 Alekai drive	Street 2 :	
City :	Pensacola	State :	FL
Country :	United States	Province :	
County :	Escambia County	Zip Code :	32526

Mailing Address

Is Mailing address and Home Address Same?	Yes	Street 2 :	
Street 1 :	8408 Alekai Dr	State :	FL
City :	Pensacola	Province :	
Country :	United States	Zip Code :	32526-2402
County :	Escambia County		

Primary Method of Contact

Primary E-mail Address :	LMiller@teampbs.com	Personal E-Mail Address :	Lacey0111@hotmail.com
PMOC CC Email1 :		PMOC CC Email2 :	

Phone Numbers

Home Phone :	850-516-5788	Personal Cell Phone :	
Personal Fax :	(772) 675-9100		

Personal Identification Numbers

Social Security Number :	439-71-0845	FNIN Country of Issue :	United States
Foreign National Identification Number :			
Do you have a Unique Physicians Identification Number (UPIN)?	No		
Do you have an Individual (Type 1) National Provider Identifier (NPI)?	Yes	Individual NPI:	1760907455

Demographics

Gender Identity:	Female	Birth City :	
Race/Ethnicity:	White	Birth Country :	Kansas City
Birth Date :	1/11/1983		United States
Birth State :	MO		

Languages

Non-English languages spoken by provider :
 provider :

PROFESSIONAL IDENTIFICATION NUMBERS**Professional License**

License State :	FL	Do you currently practice in this state?	Yes
License Number :	1-20-42649	License Type :	ABA
License Status :	Active		
Issue Date :	06/15/2020	Expiration Date :	06/15/2026

DEA Registration

Do you have a DEA Registration Certificate?	No
I do not Prescribe :	Yes
Reason For Not Having DEA :	I am not required to prescribe per my specialty

Alternate Prescriber Name :

More Information :

Controlled Dangerous Substance (CDS) Registration

Do you have a CDS Registration Certificate?	No
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Medicare

Are you a participating Medicare provider?	No
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Medicaid

Are you a participating Medicaid provider?	Yes
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Medicaid Number :	021194300	State :	FL
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ECFMG

USMLE No. :

Exam Date :

Workers Compensation Number

Workers Compensation Number :

EDUCATION

Graduate Type :	US/Canada Graduate		
Professional School Information			
Country :	United States	State :	FL
County :			
Professional School :	University of West Florida	Street 1 :	11000 university pkwy
Street 2 :		City :	pensacola
Province :			
Zip Code :	32514	Fax Number :	
Phone Number :			
Degree :	Masters of Arts (MA)	Professional School End Date :	08/2018
Professional School Start Date :	08/2016		
Area of Training / Course of Study / Major :	Applied Behavior Analysis		
Did you complete your professional education at this school?	Yes	Graduation Date :	08/10/2018

TRAINING INFORMATION**Cultural Competency Training :**Have you completed cultural competency training? **Yes**

Please select which program(s) you have completed:

SPECIALTY INFORMATION**Primary Specialty**

Primary Specialty :	Behavior Analyst (103K00000X)		
Board Certified?	Yes		
Name of Certifying Board :	Behavior Analyst Certification Board		
Country :		State :	
County :			
Street 1 :		Street 2 :	
City :		Province :	
Zip Code :			
Certification Number :		Does your board certification have an expiration date?	Yes
Initial Certification Date :	6/15/2020		
Expiration Date :	6/15/2026	Last Recertification Date :	6/15/2024
Do you wish to be listed in the directory under this primary specialty? By HMO	Yes		
Do you wish to be listed in the directory under this primary specialty? By PPO	Yes		
Do you wish to be listed in the directory under this primary specialty? By POS	Yes		

Secondary SpecialtyDo you have a Secondary Specialty? **No****Special Experience, Skills, and Training**

Please select one or more special experience, skills, and training that apply from the list below:

Issues Treated

Asperger's Syndrome, Attention Deficit/Hyperactive Disorder (ADHD), Autism Spectrum, Education and Learning Disabilities, Intellectual Disabilities

Types of Therapies

Applied Behavioral Analysis (ABA)**CERTIFICATION INFORMATION**

*** THERE IS NO DATA ON RECORD FOR THIS SECTION ***

PRACTICE LOCATIONS

Active Locations

General Information :

Confirmed Date :	8/27/2025	Providers's Start Date :	12/21/2020
Office Type :	Primary Practice		
Do you practice at this location?:	Yes, I practice at this location		
Please Explain:	I see patients by appointment at least one day per week on a regular basis		
Provider Directory Classification :			
Specialty :	Behavior Analyst	Subspecialty :	Behavior Analyst
Will you continue to practice at this location	Yes		
Type of Service provided :			
Provide a narrative description of your clinical practice including special interests :			
Practice Name :	Positive Behavior Supports Corporation - Emerald Coast		

County :
 Zip Code : 32550-1408
 Can general correspondence be sent to this location?

Appointment Scheduling Website www.teampbs.com

Mailing Address :

Street1 :	7108 S. Kanner Highway	Street2 :	
City :	Stuart	State :	FL
County :		Province :	
Country :	United States	Zip Code :	34997
Type of Practice :	Single Specialty Group	Organization (Type 2) NPI :	1700024296
Do you have an organization (Type 2) NPI? :	Yes	Group Medicare Number :	
Group Medicaid Number :	017422400	Group Medicare Number :	

Phone Numbers :

Appointment Phone Number :	855-832-6727	Phone Extention :	
Fax Number :	772-675-9100		

Back Office Phone Number :

Phone Coverage :

Does this location provide 24hour/7day a week phone coverage?:

Phone Coverage Type : **Voice Mail Other**

Tax Information :

Practice Name as it appears on the W-9 :

Tax ID :	205268843	Type of Tax ID :	Group
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Is this the primary Tax ID for this practice location?

Group Name : **Positive Behavior Supports Corp**

Network Denial :

Have you closed your practice to any plans or programs ?

No

Office Hours :

Monday			
Start Time :	9:00 AM	End Time :	5:00 PM
Tuesday			
Start Time :	9:00 AM	End Time :	5:00 PM
Wednesday			
Start Time :	9:00 AM	End Time :	5:00 PM
Thursday			
Start Time :	9:00 AM	End Time :	5:00 PM
Friday			
Start Time :	9:00 AM	End Time :	5:00 PM
Saturday			
Start Time :	None	End Time :	None
Sunday			
Start Time :	None	End Time :	None

Patients :

Do you accept new patients at this practice location?

Do you accept existing patients with change of payor at this location?

Do you accept all new patients at this location?

Do you accept new Medicare patients at this location?

Do you accept new Medicaid patients at this location?

Do you accept new CHIP patients at this location?

Do you accept new patients from physician referrals (i.e., referring letter) at this location?

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ?

Colleagues :

Do you have any Partners/Associate at this location ?

Covering Colleagues :**Mid-Level Practitioners :**

Do you have any mid-level practitioners

Middle Name :

Phone Number :

E-mail Address :

Is Office Manager Credentialing Contact

:

Billing Contact :

Office Manager & Billing Contact are same ?

Payment and Remittance :

Billing department name :

PBS Corp Billing Department

Check Payable to :

Positive Behavior Supports Corp

Electronic billing capabilities ?

Yes

Office Manager & Payee Contact are same ?

Practice Limitations and Patient Populations :

Are there any Practice Limitations ?

No

Gender Limitations :

Are there any Age Limitations ?

Only Native Americans:

Only Enrolled Students:

Other Limitations :

Accessibility :

Does this office meet ADA accessibility requirements ?

Yes

Does this office provide handicapped accessibility ?

Yes**Please specify how this location meets handicapped accessibility requirements:**

Exterior Building

No

Interior Building

No

Wheelchair access to exam room

No

Exam table/scale/chair

No

Gurneys & Stretchers

No

Portable Lifts

No

Radiologic Equipment

No

Signage & documents

No

Parking

Yes

Restroom

Yes

Other Handicapped Access :

Does this office have other services for the disabled ?

No**Please specify other services for the disabled:**

Text Telephony (TTL) :

No

American Sign Language :

No

Mental/Physical Impairment Services :

No

Other Disability Services :

Is this office accessible by public transportation ?

No**Please specify how this office is accessible by public transportation:**

Bus Transportation:

No

Subway :

No

Regional Train :

No

Other Transportation :

Does this Location Provide Child Care Services?

No

Does this office meet all state and local fire, safety and sanitation requirements?

No

Do you have TDD(hearing impaired device) available :

No

Do you accept Workers' Compensation Patients?

No

Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy?

No

Modified or alternative duty is actively evaluated for each Workers' Compensation claimant?

No

Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible

No

Staff are available and willing to provide compensation representatives information regarding a claimant's care.

No

Telehealth :

I provide telehealth services at this location:

Yes

Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Yes

Telehealth Service Type:

Audio :

No

Audio/Video :

Yes

Online Adaptive Interviews :

No

Secure Text Messaging :

No

Remote Monitoring :

No

Store-and-Forward :

No

Are you willing and able to support family caregivers?

Yes

Services :

Does this location provide any of the following services:

Laboratory Services? :

No

Accrediting/Certifying Program :

Public Health Services :

No**No**

Start Time :	8:00 AM	End Time :	5:00 PM
Thursday			
Start Time :	8:00 AM	End Time :	5:00 PM
Friday			
Start Time :	8:00 AM	End Time :	5:00 PM
Saturday			
Start Time :	None	End Time :	None
Sunday			
Start Time :	None	End Time :	None
Patients :			
Do you accept new patients at this practice location?	Yes		
Do you accept existing patients with change of payor at this location?	Yes		
Do you accept all new patients at this location?	Yes		
Do you accept new Medicare patients at this location?	Yes		
Do you accept new Medicaid patients at this location?	Yes		
Do you accept new CHIP patients at this location?	Yes		
Do you accept new patients from physician referrals (i.e., referring letter) at this location?	Yes		

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ?

No

Colleagues :

Do you have any Partners/Associate at this location ?

Covering Colleagues :

Mid-Level Practitioners :

Do you have any mid-level practitioners at this location?

Office Manager or Business Staff Contact :

First Name :	Tara	Last Name :	Reitz
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Middle Name :

Suffix :

Phone Number :

Fax Number :

E-mail Address :

Is Office Manager Credentialing Contact

:

Billing Contact :

Office Manager & Billing Contact are same ?

Payment and Remittance :

Billing department name :	Check Payable to :
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Electronic billing capabilities ?

Office Manager & Payee Contact are same ?

Practice Limitations and Patient Populations :

Are there any Practice Limitations ?

No

Gender Limitations :

Are there any Age Limitations? :

Only Native Americans:

Only Enrolled Students:

Other Limitations :

Accessibility :

Does this office meet ADA accessibility requirements ?

Yes

Does this office provide handicapped accessibility ?

Yes

Please specify how this location meets handicapped accessibility requirements:

Exterior Building	Yes
Interior Building	No
Wheelchair access to exam room	No
Exam table/scale/chair	No
Gurneys & Stretchers	No
Portable Lifts	No
Radiologic Equipment	No
Signage & documents	No
Parking	Yes

Please specify other services for the disabled:

Text Telephony (TTL) : No
 American Sign Language : No
 Mental/Physical Impairment Services : No
 Other Disability Services : No

Is this office accessible by public transportation ? No

Please specify how this office is accessible by public transportation:

Bus Transportation: No
 Subway : No
 Regional Train : No
 Other Transportation :
 Does this Location Provide Child Care Services? No
 Does this office meet all state and local fire, safety and sanitation requirements? Yes
 Do you have TDD(hearing impaired device) available : No
 Do you accept Workers' Compensation Patients? No
 Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? No
 Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? No
 Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible No
 Staff are available and willing to provide compensation representatives information regarding a claimant's care. No

Telehealth :

I provide telehealth services at this location:

Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Telehealth Service Type:

Audio :	Audio/Video :
Online Adaptive Interviews : No	Secure Text Messaging :
Remote Monitoring :	Store-and-Forward :
Are you willing and able to support family caregivers? No	

Services :

Does this location provide any of the following services:

Laboratory Services? :	Accrediting/Certifying Program :
Radiology Services :	X-ray?
X-Ray Certification Type :	EKG Services?
Care of Minor Lacerations?	Pulmonary Function testing?
Allergy Injections :	Allergy Skin Testing :
Office Gynecology?	
Drawing Blood?	Age Appropriate Immunizations?
Asthma Treatment?	Tympanometry/Audiometry Screening ?
Flexible Sigmoidoscopy?	IV Hydration treatment?
Osteopathic Manipulation?	Physical Therapy?
Cardiac Stress Test?	
Treadmill?	
Is anesthesia administered in your office ?	What class/category of anesthesia is used ?
Anesthesia Administered by First Name :	Anesthesia Administered by Last Name :
Other Services :	

Special Skills By The Practitioner :

Non-English language spoken by office personnel : Portuguese

Employee Type :

Do you have any interpreters at this location? No

General Information :

Confirmed Date : 12/21/2020

Office Type : Other Practice

Do you practice at this location?: No, I do not practice here

Please Explain: I no longer practice at this location

End Date : 12/18/2020

Provider Directory Classification :

Specialty : Subspecialty :

Will you continue to practice at this location

Type of Service provided :

Provide a narrative description of your clinical practice including special interests :

Practice Name : Sandcastle centers, LLC

Providers's Start Date : 4/7/2017

County :
 Zip Code : **32563-3350**
 Can general correspondence be sent to this location? **Yes**

Province :
 Email Address :
 Practice Location Website

FL**Appointment Scheduling Website****Mailing Address :**

Street1 :	3208 GULF BREEZE PKWY	Street2 :	
City :	GULF BREEZE	State :	FL
County :		Province :	FL
Country :	United States	Zip Code :	32563-3350

Type of Practice :

Do you have an organization (Type 2) NPI? : **Yes** Organization (Type 2) NPI: **1093217689**

Group Medicaid Number :

Group Medicare Number :

Phone Numbers :

Appointment Phone Number : **407-801-9924** Phone Extension :

Fax Number :

Back Office Phone Number :

Phone Coverage :

Does this location provide 24hour/7day a week phone coverage?: **No**

Phone Coverage Type : **Voice Mail Other****Tax Information :**

Practice Name as it appears on the W-9 : **Sandcastle Centers, LLC**

Tax ID : **824254528** Is this the primary Tax ID for this practice location? **Yes**

Type of Tax ID : **Group**

Group Name :

Network Denial :

Have you closed your practice to any plans or programs ? **No**

Office Hours :

Monday	8:30 AM	End Time :	4:30 PM
Tuesday	8:30 AM	End Time :	4:30 PM
Wednesday	8:30 AM	End Time :	4:30 PM
Thursday	8:30 AM	End Time :	4:30 PM
Friday	8:30 AM	End Time :	4:30 PM
Saturday	8:30 AM	End Time :	4:30 PM
Sunday		End Time :	
Start Time :		End Time :	

Patients :

Do you accept new patients at this practice location? **Yes**
 Do you accept existing patients with change of payor at this location? **Yes**
 Do you accept all new patients at this location? **Yes**
 Do you accept new Medicare patients at this location? **No**

Do you accept new Medicaid patients at this location? **Yes**
 Do you accept new CHIP patients at this location? **Yes**

Do you accept new patients from physician referrals (i.e., referring letter) at this location? **Yes**

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan? **No**

Colleagues :

Do you have any Partners/Associate at this location ? **No**

Covering Colleagues :

Specialty :

Provider Type :

Mid-Level Practitioners :Do you have any mid-level practitioners **No**

at this location?

Office Manager or Business Staff Contact :First Name : **Erica**

Last Name :

Kinnebrew

Middle Name :

Suffix :

Phone Number :

Fax Number :

E-mail Address :

Is Office Manager Credentialing Contact **No**

:

Billing Contact :Office Manager & Billing Contact are **Yes**

same ?

First Name :

Middle Name :

Last Name :

Street 1 :

Billing Company Name :

City :

Street 2 :

Province :

State:

Zip Code :

Country :

Fax Number :

Phone Number :

E-mail Address :

Payment and Remittance :

Billing department name :

Check Payable to :

Sandcastle Centers, LLCElectronic billing capabilities ? **Yes**Office Manager & Payee Contact are **Yes**

same ?

First Name :

Middle Name :

Last Name :

Street 1 :

Street 2 :

City :

State:

Province :

Country :

Zip Code :

Phone Number :

Fax Number :

E-mail Address :

Practice Limitations and Patient Populations :Are there any Practice Limitations ? **No**Gender Limitations : **No**Are there any Age Limitations? : **No**

Only Native Americans:

Yes

Only Enrolled Students:

Yes

Other Limitations :

Accessibility :Does this office meet ADA accessibility requirements ? **Yes**Does this office provide handicapped accessibility ? **Yes****Please specify how this location meets handicapped accessibility requirements:**

Exterior Building

Yes

Interior Building

Yes

Wheelchair access to exam room

Yes

Exam table/scale/chair

No

Gurneys & Stretchers

No

Portable Lifts

Yes

Radiologic Equipment

No

Signage & documents

Yes

Parking

Yes

Restroom

Yes

Other Handicapped Access :

Does this office have other services for the disabled ? **No****Please specify other services for the disabled:**

Text Telephony (TTL) :

No

American Sign Language :

No

Mental/Physical Impairment Services :

No

Other Disability Services :

Is this office accessible by public transportation ? **Yes****Please specify how this office is accessible by public transportation:**

Bus Transportation:

Yes

Subway :

No

Regional Train :

No

Other Transportation :

Does this Location Provide Child Care Services? **No**Does this office meet all state and local fire, safety and sanitation requirements? **Yes**Do you have TDD(hearing impaired device) available : **No**Do you accept Workers' Compensation Patients? **No**

Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible
Staff are available and willing to provide compensation representatives information regarding a claimant's care.

Telehealth :

I provide telehealth services at this location:

Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)?

Telehealth Service Type:

Audio :

Online Adaptive Interviews :

No

Audio/Video :

Secure Text Messaging :

Store-and-Forward :

Remote Monitoring :

Are you willing and able to support family caregivers?

Services :

Does this location provide any of the following services:

Laboratory Services? :

Yes

Accrediting/Certifying Program :

Radiology Services :

No

X-ray?

X-Ray Certification Type :

EKG Services?

Care of Minor Lacerations?

Pulmonary Function testing?

Allergy Injections :

Allergy Skin Testing :

Office Gynecology?

Age Appropriate Immunizations?

Drawing Blood?

Tympanometry/Audiometry Screening ?

Asthma Treatment?

IV Hydration treatment?

Flexible Sigmoidoscopy?

Physical Therapy?

Osteopathic Manipulation?

Cardiac Stress Test?

Treadmill?

Is anesthesia administered in your office

What class/category of anesthesia is used ?

?

Anesthesia Administered by First Name

Anesthesia Administered by Last Name :

:

Other Services :

Special Skills By The Staff :

Special Skills By The Practitioner :

Non-English language spoken by office personnel :

Employee Type :

Do you have any interpreters at this location? **No**

HOSPITAL AFFILIATIONS**General :**

Do you have admitting privileges at one or more hospitals?

No

Do you have an admitting arrangement where another provider admits for you?

No

Do you have any non-admitting hospital affiliations?

No

CREDENTIALING INFORMATION

First Name :	Latoya	Middle Name :	
Last Name :	Magill	Street 1 :	7108 S Kanner Hwy
Street 2 :		City :	Stuart
State :	FL	Zip Code :	34997-7462
Country :	United States	Province :	
Phone Number :	855-832-6727	Fax Number :	772-675-9100
Email Address :	LMagill@teampbs.com		
Primary Credentialing Contact :	Yes	Location :	Positive Behavior Supports Corporation - Emerald Coast
Location Type :	PracticeLocation	Middle Name :	
First Name :		Street 1 :	
Last Name :		City :	
Street 2 :		Zip Code :	
State :		Province :	
Country :		Fax Number :	
Phone Number :			
Email Address :			
Primary Credentialing Contact :			
Location Type :			

INSURANCE INFORMATION

Policy Number :	6799172
Covered Practice Locations :	Positive Behavior Supports Corporation - Emerald Coast
Claimant ID :	0102410007

Carrier/Self Insured Name : **Lexington Insurance Company**
 Street 1 : **99 High Street** Street 2 :
 City : **Boston** Province :
 State : **MA** Country : **United States**
 Zip Code : **02110** Phone Number : **617-330-1100**
 Phone Extension : Fax Number : **866-671-9288**

Do you have unlimited coverage with this insurance carrier? **No**

Type of coverage : **Occurrence** Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? **No**

Individual Coverage : **No** Self-Insured? **No**

Policy Number : **6799172**

Covered Practice Locations : **Positive Behavior Supports Corporation - Emerald Coast**

Original Effective Date : **01/31/2026**

Current Effective Date : **01/31/2024**

Current Expiration Date : **01/31/2025**

Carrier/Self Insured Name : **Lexington Insurance Company**

Street 1 : **99 High Street**

City : **Boston** Street 2 :
 State : **MA** Province :
 Country : **United States**

Zip Code : **02110** Phone Number : **617-330-1100**

Phone Extension : Fax Number : **866-671-9288**

Do you have unlimited coverage with this insurance carrier? **No**

Type of coverage : **Occurrence** Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? **No**

Individual Coverage : **No**

Self-Insured? **No**

Policy Number : **MEO4026591.23**

Covered Practice Locations : **Positive Behavior Supports Corporation - Emerald Coast**

Original Effective Date : **01/31/2021**

Current Effective Date : **01/31/2023**

Current Expiration Date : **01/31/2024**

Carrier/Self Insured Name : **Lloyd's of London c/o Risk Placement Services**

Street 1 : **2002 N Lois Ave., ste 130**

City : **Tampa** Street 2 :
 State : **FL** Province :
 Zip Code : **33607** Country : **United States**

Phone Extension : Fax Number : **813-257-6308**

Do you have unlimited coverage with this insurance carrier? **No**

Type of coverage : **Occurrence** Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? **No**

Individual Coverage : **No**

Self-Insured? **No**

Policy Number : **MEO4026591.22**

Covered Practice Locations : **Positive Behavior Supports Corporation - Emerald Coast**

Original Effective Date : **01/31/2021**

Current Effective Date : **01/31/2022**

Current Expiration Date : **01/31/2023**

Carrier/Self Insured Name : **Lloyds of London**

Street 1 : **10 Fairway Dr Ste 101**

City : **Deerfield Beach** Street 2 :
 State : **FL** Province :
 Zip Code : **33607** Country : **United States**

Phone Extension : Fax Number : **813-257-6308**

Do you have unlimited coverage with this insurance carrier? **No**

Type of coverage : **Occurrence** Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? **No**

Covered Practice Locations :
 Original Effective Date : **01/31/2021**
 Current Effective Date : **01/31/2021**
 Current Expiration Date : **01/31/2022**
 Carrier/Self Insured Name : **Banak insurance agency**
 Street 1 : **800 virginia ave** Street 2 :
 City : **fort pierce** Province :
 State : **FL** Country : **United States**
 Zip Code : **34997** Phone Number :
 Fax Number :
 Phone Extension :
 Do you have unlimited coverage with this insurance carrier? **No**
 Type of coverage : **Occurrence**
 Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$3,000,000.00**
 If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?
 Individual Coverage : **No**
 Self-Insured? **No**
 Policy Number : **U15721**
 Covered Practice Locations :
 Original Effective Date :
 Current Effective Date : **12/21/2020**
 Current Expiration Date : **12/21/2021**
 Carrier/Self Insured Name : **CM&F Group, Inc.**
 Street 1 : **99 Hudson Street** Street 2 :
 City : **New York** Province :
 State : **NY** Country :
 Zip Code :
 Phone Extension :
 Do you have unlimited coverage with this insurance carrier? **Yes**
 Type of coverage :
 Amount of coverage per occurrence : **\$1,000,000.00** Amount of coverage aggregate : **\$6,000,000.00**
 If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?
 Individual Coverage : **Yes**
 Self-Insured? **Yes**

WORK HISTORY INFORMATION

Employment Information Record

Practice/Employer Name :	Positive Behavior Supports Corporation - Emerald Coast	Department :	ABA Therapy
Street 1 :	495 Grand Boulevard Suite 206	Street 2 :	
Country :	United States	State :	FL
City :	Miramar Beach	Zip Code :	32550-1408
Province :			
Phone Number :	855-832-6727	Phone Extension :	
Fax Number :	772-675-9100		
Start Date :	01/2021		
Is this your current employer?	Yes		
Practice/Employer Name :	Sandcastle Centers, LLC	Department :	
Street 1 :	3802 gulf breeze pkwy	Street 2 :	
Country :	United States	State :	FL
City :	gulf breeze	Zip Code :	32563
Province :			
Phone Number :		Phone Extension :	
Fax Number :			
Start Date :	04/2017		
Is this your current employer?	No		
End Date :	12/2020	Reason for departure :	Company Financial Decision
Practice/Employer Name :	Santa Rosa County School Board	Department :	
Street 1 :	6032 US 90	Street 2 :	
Country :	United States	State :	FL
City :	MILTON	Zip Code :	32570
Province :		Phone Extension :	
Phone Number :			
Fax Number :			
Start Date :	01/2012		
Is this your current employer?	No		
End Date :	12/2017	Reason for departure :	NEW POSITION
Practice/Employer Name :	MOBILE COUNTY SCHOOL DISTRICT	Department :	
Street 1 :	1 MAGNUS PASS	Street 2 :	

Phone Number :

Fax Number :

Start Date :

01/2009

Is this your current employer?

No

End Date :

01/2011

Reason for departure :

NEW POSITION**Employment Gap Record :**

Start Date:

02/2011

End Date:

12/2011

Gap Explanation:

Other (please specify)

Reason:

English program in Korea

Start Date:

08/2016

End Date:

08/2018

Gap Explanation:

Academic/Training leave**Military :**

Are you currently on active military duty?

NoAre you currently in the Reserves or
National Guard?**No****REFERENCES INFORMATION**

Provider Type :

josh

Middle Name :

First Name :

McGrew

Last Name :

Oriole Beach Road

Street 2 :

Street 1 :

gulf breeze

State :

FL

City:

Zip Code :

Province :

Email Address :

Country :

850-723-1925

Phone Number :

Fax Number :

Provider Type :

Kathleen

Middle Name :

First Name :

murdock

Last Name :

pensacola

Street 2 :

Street 1 :

State :

City:

Zip Code :

Province :

Email Address :

Country :

850-748-6097

Phone Number :

Fax Number :

Provider Type :

Logan

Middle Name :

First Name :

Thomas

Last Name :

gulf breeze

Street 2 :

Street 1 :

State :

City:

Zip Code :

Province :

Email Address :

Country :

850-320-0639

Phone Number :

Fax Number :

DISCLOSURE INFORMATION**CAQH :****Licensure :**

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? **No**

2. Has there been any challenge to your licensure, registration or certification? **No**

Hospital Privileges and Other Affiliations :

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? **No**

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? **No**

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? **No**

Education, Training and Board Certification :

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? **No**

7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? **No**

8. Have any of your board certifications or eligibility ever been revoked? **No**

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? **No**

DEA or CDS :

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? **No**

Medicare, Medicaid or other Governmental Program Participation :

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans **No**

program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? **No**

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? **No**

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? **No**

16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? **No**

Professional Liability Insurance Information and Claims History :

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? **No**

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? **No**

Malpractice Claims History :

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case. **No**

Criminal/Civil History :

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? **No**

21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct? **No**

22. Have you ever been court-martialed for actions related to your duties as a medical professional? **No**

Ability to Perform Job :

23. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.) **No**

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? **No**

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? **No**

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? **No**