CAQH Data Summary Date 2/26/2018
Berting, Hadley Mates Professional Counselor
CAQH Provider ID : 13959539

Last Reattestation Date: 2/19/2018 10:15:32 AM

## PREPARE

| | | | |
|---|---|---|---|
| Provider Type: | **Professional Counselor** | Practice Setting: | **Inpatient/Outpatient or Outpatient Only** |
| Primary Practice State: | **NC** | | |
| Other Practice State(s): | | | |

## PERSONAL INFORMATION

**Name**

| | | | |
|---|---|---|---|
| First Name : | **Hadley** | Middle Name : | **Mates** |
| Last Name : | **Berting** | Suffix : | |
| Have you used other names? | **No** | | |

**Home Address**

| | | | |
|---|---|---|---|
| Street 1 : | **701 West Main Street** | Street 2 : | |
| City : | **Washington** | State : | **NC** |
| Country : | **United States** | Province : | |
| County : | **Beaufort County** | Zip Code : | **27889** |

**Mailing Address**

| | | | |
|---|---|---|---|
| Is Mailing address and Home Address Same? | Yes | | |
| Street 1 : | **701 W MAIN ST** | Street 2 : | |
| City : | **WASHINGTON** | State : | **NC** |
| Country : | **United States** | Province : | |
| County : | | Zip Code : | **27889-4727** |

**Primary Method of Contact**

| | | | |
|---|---|---|---|
| Primary E-mail Address : | hberting@dreamprovidercare.net | Personal E-Mail Address : | |
| PMOC CC Email1 : | | PMOC CC Email2 : | |

**Phone Numbers**

| | | | |
|---|---|---|---|
| Home Phone : | | Personal Cell Phone : | **910-512-7988** |
| Personal Fax : | | | |

**Personal Identification Numbers**

| | | | |
|---|---|---|---|
| Social Security Number : | **246-61-8918** | | |
| Foreign National Identification Number : | | FNIN Country of Issue : | |
| Do you have a Unique Physicians Identification Number (UPIN)? | **No** | | |
| Do you have an Individual (Type 1) National Provider Identifier (NPI)? | **Yes** | Individual NPI : | **1023416724** |

**Demographics**

| | | | |
|---|---|---|---|
| Gender : | **Female** | Race/Ethnicity : | **White/Caucasian** |
| Birth Date : | **10/14/1988** | Birth City : | **Wilmington** |
| Birth State : | **NC** | Birth Country : | |

**Languages**

| | |
|---|---|
| Non-English languages spoken by provider : | |

## PROFESSIONAL IDENTIFICATION NUMBERS

**Professional License**

| | | | |
|---|---|---|---|
| License State : | **NC** | Do you currently practice in this state? | **Yes** |
| License Number : | **12773** | License Type : | |
| License Status : | **Active** | | |
| Issue Date : | **01/26/2017** | Expiration Date : | **06/30/2018** |

**DEA Registration**

| | |
|---|---|
| Do you have a DEA Registration Certificate? | **No** |

**Controlled Dangerous Substance (CDS) Registration**

| | |
|---|---|
| Do you have a CDS Registration Certificate? | **No** |

**Medicare**

| | |
|---|---|
| Are you a participating Medicare provider? | **No** |

**Medicaid**

| | |
|---|---|
| Are you a participating Medicaid provider? | **No** |

**ECFMG**

| | |
|---|---|
| Do you have a Educational Commission for Foreign Medical Graduates (ECFMG) Number? | **No** |

**USMLE**

| | | | |
|---|---|---|---|
| USMLE No. : | | Exam Date : | |

## EDUCATION

| | | | |
|---|---|---|---|
| Graduate Type : | **US/Canada Graduate** | | |

**Professional School Information**

| | | | |
|---|---|---|---|
| Country : | **United States** | State : | **NC** |
| County : | **Orange County** | | |
| Professional School : | **University of North Carolina At Chapel Hill** | Street 1 : | **121 MacNider 202H** |
| Street 2 : | | City : | **Chapel Hill** |
| Province : | | | |
| Zip Code : | **27514** | | |
| Phone Number : | | Fax Number : | |
| Degree : | **Licensed Professional Counselor (LPC)** | | |

| | | | |
|---|---|---|---|
| Professional School Start Date : | **08/2012** | Professional School End Date : | **05/2014** |
| Area of Training / Course of Study / Major : | **Rehabilitation Counseling** | | |
| Did you complete (or will you complete within the next 90 days) your professional education at this school? | **Yes** | Completion Date : | **05/11/2014** |

**Professional School Information**

| | | | |
|---|---|---|---|
| Country : | **United States** | State : | **NC** |
| County : | | | |
| Professional School : | **University of North Carolina at Chapel Hill School of Medicine** | Street 1 : | **School of Medicine** |
| Street 2 : | | City : | **Chapel Hill** |
| Province : | | | |
| Zip Code : | **27599** | | |
| Phone Number : | | Fax Number : | |
| Degree : | **Master of Science Psychology (MSPSY)** | | |
| Professional School Start Date : | **04/2012** | Professional School End Date : | **05/2014** |
| Area of Training / Course of Study / Major : | **Rehabilitation Counseling & Psychology** | | |
| Did you complete (or will you complete within the next 90 days) your professional education at this school? | **Yes** | Completion Date : | **05/11/2014** |

**Undergraduate Education**

| | | | |
|---|---|---|---|
| Country : | **United States** | State : | **TN** |
| School : | **University of the South** | Street 1 : | **University Avenue** |
| Street 2 : | | City : | **Sewanee** |
| Province : | | | |
| Zip Code : | **37375** | | |
| Phone Number : | | Fax Number : | |
| Degree : | **Bachelor of Science (BS)** | | |
| Start Date : | **08/2007** | End Date : | **05/2011** |
| Area of Training / Course of Study / Major : | **Psychology** | | |
| Did you complete your Undergraduate education at this school? | **Yes** | Completion Date : | **05/08/2011** |

## TRAINING INFORMATION

**Internship :**

Did you do any internships? Yes

If your Residency information was migrated from UPD to CAQH ProView but appears on the Internship section, use the "Type" field to move data from the Internship to the Residency section.Select "Residency" from the type list and then click Save & Continue.

| | | | |
|---|---|---|---|
| Type : | **Internship** | | |
| Country : | **United States** | State : | **NC** |
| County : | | | |
| Institution/Hospital Name : | **University of North Carolina at Chapel Hill School of Medicine** | Affiliated University : | |
| Street1 : | **School of Medicine** | Street2 : | |
| City : | **Chapel Hill** | Province : | |
| Zip Code : | **27599** | Phone : | |
| Phone Extension : | | Fax Number : | |
| Email Address : | | Start Date : | **01/2014** |
| End Date : | **05/2014** | Type of Program : | **Straight** |
| Department : | **UNC Center for Excellence in Community Mental Health** | | |
| Specialty : | | Name of Director : | |
| Did you complete (or will you complete within the next 90 days) the training program at this institution? | **Yes** | Completion Date : | **5/05/2014** |

**Continuing Medical Education(CME) :**

Do you have Continuing Medical Education ? No

## SPECIALTY INFORMATION

**Primary Specialty**

Do you have any specialties? **No**

## CERTIFICATION INFORMATION

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

## PRACTICE LOCATIONS

**General Information :**

| | | | |
|---|---|---|---|
| Office Type : | **Primary Practice** | Providers's Start Date : | **3/27/2017** |
| Do you practice at this location?: | **Yes, I practice at this location** | | |
| Please Explain: | **I see patients here at least one day per week on a regular basis** | | |
| Physician Group/Practice Name : | **Dream Provider Care Services Inc.** | | |
| CAQH Practice Location Number : | **c8144280-cf04-e711-b2dc-0050569b7a06** | Street 1 : | **216 STEWART PKWY** |
| Street 2 : | | Country : | **United States** |
| City : | **WASHINGTON** | State : | **NC** |
| County : | **Beaufort County** | Province : | |
| Zip Code : | **27889-4972** | Email Address : | www.dreampcs@aol.com |
| | **Yes** | Practice Location Website | **www.dreamprovidercare.com** |

| | | | |
|---|---|---|---|
| Can general correspondence be sent to this location? | | | |
| **Mailing Address :** | | | |
| Street1 : | **216 STEWART PKWY** | Street2 : | |
| City : | **WASHINGTON** | State : | **NC** |
| County : | **Beaufort County** | Province : | |
| Country : | **United States** | Zip Code : | **27889-4972** |
| Type of Practice : | **Corporation** | | |
| Subspecialty : | | | |
| Provide a narrative description of your clinical practice including special interests : | | | |
| Type of Service provided : | **Primary Care** | | |
| Do you have an organization (Type 2) NPI? : | **Yes** | Organization (Type 2) NPI : | **1912952672** |
| Group Medicaid Number : | **6005782** | Group Medicare Number : | |
| **Phone Numbers :** | | | |
| Office Phone Number : | **252-946-0585** | Phone Extention : | |
| Fax Number : | **252-946-0580** | | |
| **Phone Coverage :** | | | |
| Does this location provide 24hour/7day a week phone coverage?: | **Yes** | | |
| **Tax Information :** | | | |
| Tax ID : | **200099693** | Type of Tax ID : | **Group** |
| Is this the primary Tax ID for this practice location? | **Yes** | | |
| Group Name : | **Dream Provider Care Services, Inc.** | | |
| **Office Hours :** | | | |
| Monday | | | |
| Start Time : | **10:00 AM** | End Time : | **5:00 PM** |
| Tuesday | | | |
| Start Time : | **10:00 AM** | End Time : | **5:00 AM** |
| Wednesday | | | |
| Start Time : | **10:00 AM** | End Time : | **5:00 AM** |
| Thursday | | | |
| Start Time : | **10:00 AM** | End Time : | **5:00 PM** |
| Friday | | | |
| Start Time : | **10:00 AM** | End Time : | **4:00 PM** |
| Saturday | | | |
| Start Time : | **8:00 AM** | End Time : | **8:00 PM** |
| Sunday | | | |
| Start Time : | | End Time : | |
| Do you accept new patients into the practice? | **Yes** | | |
| ExplanationOfVariations : | | | |
| **Colleagues :** | | | |
| Do you have any Partners/Associate at this location ? | **Yes** | | |
| **Partners/Associates :** | | | |
| Colleague Type : | **Partner** | | |
| First Name : | **Dwayne** | Middle Name : | **G** |
| Last Name : | **Bryant** | Suffix : | |
| Specialty : | **Psychiatry & Neurology, Addiction Psychiatry** | Provider Type : | **MD** |
| License Number : | | Does this partner/associate provide coverage for you : | **No** |
| **Covering Colleagues :** | | | |
| First Name : | **Tania** | Middle Name : | |
| Last Name : | **Obremski** | | |
| Title : | **FNP** | | |
| Street 1 : | **216 Stewart Parkway** | Street 2 : | |
| City : | **Washington** | State : | **NC** |
| Zip Code : | **27889** | | |
| **Mid-Level Practitioners :** | | | |
| Do you have any mid-level practitioners at this location? | **No** | | |
| **Office Manager or Business Staff Contact :** | | | |
| First Name : | **Adreanne** | Last Name : | **Turner** |
| Middle Name : | | Suffix : | |
| Phone Number : | **252-946-0585** | Fax Number : | **252-946-0580** |
| E-mail Address : | adreanneturner@dreamprovidercare.net | | |
| Is Office Manager Credentialing Contact : | **Yes** | | |
| **Billing Contact :** | | | |
| Office Manager & Billing Contact are same ? | **Yes** | | |
| First Name : | | Middle Name : | |
| Last Name : | | Street 1 : | |
| Billing Company Name : | | | |
| Street 2 : | | City : | |
| State: | | Province : | |
| Country : | | Zip Code : | |
| Phone Number : | | Fax Number : | |
| E-mail Address : | | | |
| **Payment and Remittance :** | | | |
| Billing department name : | **Dream Provider Care Services, Inc.** | Check Payable to : | **Wendee Bailey** |
| Electronic billing capabilities ? | **Yes** | | |
| | **Yes** | | |

| | | | |
|---|---|---|---|
| Office Manager & Payee Contact are 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 :** | | | |
| Gender Limitations : | **No** | | |
| Are there any Age Limitations? : | **No** | | |
| Other Limitations : | **N/A** | | |
| What population(s) do you treat (e.g. geriatric, all ages): | **All ages.** | | |
| **Accessibility :** | | | |
| Does this office meet ADA accessibility requirements ? | | **Yes** | |
| Does this office provide handicapped accessibility ? | | | |
| Building Access : | **Yes** | | |
| Parking Access : | **Yes** | | |
| Restroom Access : | **Yes** | | |
| Wheelchair Access : | **Yes** | | |
| **Services :** | | | |
| Does this location provide any of the following services: | | | |
| Laboratory Services? : | **No** | Accrediting/Certifying Program : | |
| Radiology Services : | **No** | | |
| X-Ray Certification Type : | | EKG Services? | **No** |
| Care of Minor Lacerations? | **No** | Pulmonary Function testing? | **No** |
| Allergy Injections : | **No** | Allergy Skin Testing : | **No** |
| Office Gynecology? | **No** | | |
| Drawing Blood? | **No** | | |
| Asthma Treatment? | **No** | Age Appropriate Immunizations? | **No** |
| Flexible Sigmoidoscopy? | **No** | Tympanometry/Audiometry Screening ? | **No** |
| Osteopathic Manipulation? | **No** | IV Hydration treatment? | **No** |
| Cardiac Stress Test? | **No** | Physical Therapy? | **No** |
| Is anesthesia administered in your office ? | **No** | What class/category of anesthesia is used ? | **None** |
| Anesthesia Administered by First Name : | | Anesthesia Administered by Last Name : | |
| Other Services : | | | |
| Non-English language spoken by office personnel : | **Spanish** | Employee Type : | **Interpreter** |
| Do you have any interpreters at this location? | **Yes** | | |
| Specify languages : | **Spanish** | Employee Type : | **Interpreter** |

**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? | **Yes** |
| Do you have any non-admitting hospital affiliations? | **No** |
| Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board. : | **N/A** |

| | | | |
|---|---|---|---|
| **Admitting Arrangements :** | | | |
| **1.** Country : | **United States** | State : | **NC** |
| Hospital Name : | **Vidant Medical Center** | | |
| Street 1 : | **2100 Stantonsburg Road** | Street 2 : | |
| City : | **Greenville** | | |
| Zip Code : | **27834** | | |
| Phone Number : | **252-847-4100** | | |
| Admitting Arrangement Status : | **Active** | | |
| Start Date : | **03/2017** | | |
| Who admits for you? : | **A provider in my practice** | | |
| First Name: | **Dwayne** | | |
| Last Name: | **Bryant** | | |
| Is the admitting provider's specialty the same as your specialty? : | **No** | | |
| Phone Number : | **252-946-0585** | Email Address | |
| Individual NPI Number (Type 1): | | Please describe the admitting arrangement: | |

**CREDENTIALING INFORMATION**

| | | | |
|---|---|---|---|
| First Name : | **Adreanne** | Middle Name : | |
| Last Name : | **Turner** | Street 1 : | **216 Stewart Parkway** |
| Street 2 : | | City : | **Washington** |
| State : | **NC** | Zip Code : | **27889** |
| Country : | **United States** | Province : | |
| Phone Number : | **252-946-0585** | Fax Number : | **252-946-0580** |
| Email Address : | adreanneturner@dreamprovidercare.net | | |
| Primary Credentialing Contact : | **Yes** | | |
| Location Type : | **PracticeLocation** | Location : | **Dream Provider Care Services Inc.** |

**INSURANCE INFORMATION**

| | | | |
|---|---|---|---|
| Are You Covered Under A Professional Liability Insurance Policy? | **Yes** | | |
| Policy Number : | **0646666090-8** | | |
| Original Effective Date : | **03/09/2017** | | |
| Current Effective Date : | **03/09/2017** | | |
| Current Expiration Date : | **03/09/2018** | | |
| Carrier/Self Insured Name : | **Hpso (Health Providers Service Organizational** | | |
| Street 1 : | **159 E County Line Rd** | Street 2 : | |
| City : | **Hatboro** | Province : | |
| State : | **PA** | Country : | |
| Zip Code : | **19040** | Phone Number : | |
| Phone Extension : | | Fax Number : | |
| Type of coverage : | | | |
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$5,000,000.00** |
| 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 : | **Yes** | | |

**WORK HISTORY INFORMATION**

**Employment Information Record**

| | | | |
|---|---|---|---|
| Practice/Employer Name : | **Dream Provider Care Services, Inc,** | Department : | |
| Street 1 : | **216 Stewart Parkway** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Washington** | State : | **NC** |
| Province : | | Zip Code : | **27889** |
| Phone Number : | **252-946-0585** | Phone Extension : | |
| Fax Number : | **252-946-0580** | | |
| Start Date : | **03/2017** | | |
| Is this your current employer? | **Yes** | | |
| Practice/Employer Name : | **Kitsap Mental Health Services** | Department : | **Child & Family** |
| Street 1 : | **5455 Almira Drive** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Bremerton** | State : | **WA** |
| Province : | | Zip Code : | **98311** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **11/2014** | | |
| Is this your current employer? | **No** | | |
| End Date : | **11/2016** | Reason for departure : | **Moved out of state** |
| Practice/Employer Name : | **UNC Chapel Hill** | Department : | **Center for Excellence in Community Mental Health** |
| Street 1 : | **200 N Greensboro St** | Street 2 : | **Suite C-6 Second Floor** |
| Country : | **United States** | | |
| City : | **Carrboro** | State : | **NC** |
| Province : | | Zip Code : | **27510** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **01/2014** | | |
| Is this your current employer? | **No** | | |
| End Date : | **05/2014** | Reason for departure : | **This was my internship for graduate school. I moved out of state after graduation.** |
| Practice/Employer Name : | **Easter Seals UCP** | Department : | |
| Street 1 : | **3801 Lake Boone Trail** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Raleigh** | State : | **NC** |
| Province : | | Zip Code : | **27607** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **08/2013** | | |
| Is this your current employer? | **No** | | |
| End Date : | **12/2013** | Reason for departure : | **This was my practicum for graduate school.** |

**Employment Gap Record :**

| | | | |
|---|---|---|---|
| Start Date: | **11/2016** | End Date: | **03/2017** |
| Gap Explanation: | **Other (please specify)** | Reason: | **Husband retired from military and we moved across the country.** |
| Start Date: | **06/2014** | End Date: | **11/2014** |
| Gap Explanation: | **Other (please specify)** | Reason: | **Husband was relocated to Charleston, SC for 5 months for a military training. I worked retail at this time while searching for my position in our next location.** |

**Military :**

| | | | |
|---|---|---|---|
| Are you currently on active military duty? | **No** | Are you currently in the Reserves or National Guard? | **No** |

**REFERENCES INFORMATION**

| | | | |
|---|---|---|---|
| Provider Type : | **Professional Counselor** | | |
| First Name : | **Donald** | | |
| Last Name : | **Moriarty** | | |
| Street 1 : | **5455 Almira Drive** | Street 2 : | |
| City: | **Bremerton** | State : | **WA** |
| Province : | | Zip Code : | **98311** |
| Country : | **United States** | Email Address : | donf@kmhs.org |
| Phone Number : | **360-479-4994** | | |

| | | | |
|---|---|---|---|
| Fax Number : | | | |
| Provider Type : | **Professional Counselor** | | |
| First Name : | **Michelle** | | |
| Last Name : | **Connell** | | |
| Street 1 : | **2535 Mitchell Road** | Street 2 : | |
| City: | **Port Orchard** | State : | **WA** |
| Province : | | Zip Code : | **98366** |
| Country : | | Email Address : | |
| Phone Number : | **360-373-7049** | | |
| Fax Number : | | | |

**DISCLOSURE INFORMATION**

**NC :**

| | |
|---|---|
| 1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? | **No** |
| 2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? | **No** |
| 3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under threat of investigation or are any such actions pending? | **No** |
| 4. Have you ever been sanctioned or suspended by Medicare or Medicaid? | **No** |
| 5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? | **No** |
| 6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? | **No** |
| 7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? | **No** |
| 8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? | **No** |
| 9. Have you ever practiced without liability coverage? | **No** |
| 10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential function of your position? | **No** |
| 11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? | **No** |