Create an Account!

Register as Doctor | Register as Provider

First Name *

Last Name *

Enter Your Email *

Please provide your phone number preferred for correspondence *

Name of Practice (if applicable)

Current Licensure

Please describe your collaborative need *

Which forms of communication are best for your collaborative needs? *

In which states will you be practicing? *

How often would you like to communicate with your collaborative physician? *

Please specify your EMR system, if applicable

Meeting time suggestions for prospective collaborative D4P physicians

every Monday at 9 am for 30 min, first Thursday of each month, etc

Do you currently have malpractice or a professional liability insurance policy? *

Would you like an insurance agent to contact you about getting you a malpractice policy?

Please select

Do you already have a billing company? *

Please select

Would you like to be contacted by a prospective billing company?

Please select

MonthlMonthly budget allotted for collaborative needsy Budget *

What is the % of charts thats will need to be reviewed every month *

Any additional notes regarding your practice, collaborative needs, or questions to address within your intake meeting

Does the provider need prescriptive authority *

Will the provider need to speak to the collaborating physician by phone. If yes, how often

Will the provider be prescribing any controlled substances *

Any other unique requests?

(Ex in NY the physician needs to own the practice)

Upload CV (CV must be word format)

Drop files here to upload

Save