2007/2008 HIV Services Directory

Healthcare Provider Update Form

Name	
Practice Name	
Address	
City	
State	
Zip	
Complete Phone #	
Complete Fax #	
Complete TDD/TTY #	
Email Address	
Website	
Hospital Affiliation	

Published by:

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Geographic Location: (This refers both to your agency's physical location and your service area. Check all that apply.)

- ☐ A-Dow ntow n
- ☐ B-North Side
- ☐ C-South Side
- ☐ D-West Side
- ☐ E-North Suburbs
- ☐ F-Northw est Suburbs
- ☐ G-South Suburbs
- ☐ H-Southw est Suburbs
- ☐ I-West Suburbs

Fees: ☐

D=Medicaid
E=Set Fee
F=Free
I=Private Insurance
P=Public Aid Accepted
Q=Medicare
S=Sliding Scale

Provider Type: ☐

Provider Types
1-Physician
2-Pharmacist
3-Alternative
4-Mental Health
5-Dental

☐ No ☐ Yes **Evening/Weekend Hours Available?**
☐ No ☐ Yes **Is the Facility Handicap Accessible?**

Medical Specialties:

- ☐ Allergy-Immunology
- ☐ Cardiology
- ☐ Dental
- ☐ Dermatology
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ Infectious Diseases
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Orthopedic
- ☐ Otolaryngology
- ☐ Pediatric
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Psychiatric

Alternative Therapies:

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Exercise
- ☐ Homeopathic
- ☐ Hypnotherapy
- ☐ Massage
- ☐ Meditation
- ☐ Nutritionist
- ☐ Reiki
- ☐ Tai Chi
- ☐ Yoga

Pharmaceutical Services:

- ☐ Prescriptions
- ☐ Supplements
- ☐ Delivery
- ☐ Mail

Mental Health:

- ☐ Addiction
- ☐ Couples
- ☐ Depression/Suicide
- ☐ Domestic Violence/Abuse
- ☐ Family
- ☐ Grief/Loss
- ☐ Group
- ☐ Individual
- ☐ Relationships
- ☐ Sexual Identity
- ☐ Sexual Issues

Languages: ☐

If you wish, you may provide a brief description of your practice in English and/or Spanish

English Description:

Spanish Description:

Confirmation Signature: ☐ **Date Signed:** ☐

(Required for your organization to be included in the Directory)