

Texas CPAN Practice Participation Agreement

Practice Name:

Main Practice Address:

Practice Main Telephone Number:

Practice Fax(es):

Practice Medical Director/Physician Leader Name and Email:

- 1.
- 2.

Please add all physician names/emails within this practice:

- 1.
- 2.
- 3.

Practice Nurse Practitioners and/or Physician Assistant names and emails within this practice including their Physician Supervisor:

- 1.
- 2.
- 3.

Practice Office Manager(s)/Practice Office Manager Names and Email(s):

- 1.
- 2.
- 3.

Referral or Nurse Coordinator(s) Names and Email/Phone Extension

- 1.
- 2.
- 3.

ACO / Physician Organization / Health System Affiliation(s): (if applicable)

Additional Site(s) (If applicable) #1 Address:

By enrolling in the Texas CPAN Program, primary care providers will be provided with the following:

- Child and Adolescent Psychiatry Continuing Medical Education (live and webinar)
- Access to Child and Adolescent Psychiatry Consultants within 30 min via telephone during normal business hours (initial and ongoing consultations are provided)- these are provided to

providers consultations and are not designed to provide direct care to patients by the child psychiatrist

- CPAN website access (includes educational material)
- Assistance with psychiatry and related referrals

By enrolling in the Texas CPAN Program:

- I/We agree to participate in the Texas Child Psychiatry Access Network with the following Regional Team
- I/We agree to, when possible, participate in CPAN consultation, training and educational opportunities.
- I/We agree to inform patients that we may engage the CPAN program on their behalf and will share health information with the program unless the patient declines the CPAN services.
- I/We agree to complete periodic satisfaction surveys.

Signed: _____ Title: _____ Date: _____