Chiropractic Supplemental

Please complete for each Chiropractor in the office

Applicant's Name and Degree designation(s): ______________________________

Social Security Number: ________ - ______ - ________ Date of Birth _____ / _____ / ________

Practice Address: ______________________________

E-Mail Address: ______________________ Website Address: ______________________

Are you a U.S. Citizen? Yes No If no, indicated status and date of entry ______________________

1. License Information

a. Chiropractic License Number(s): ______________________________

b. State(s) Licensed: ______________________________

c. Are you licensed to practice any other health care practices? YES NO

If yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: ____________

2. List all locations and dates where you have practiced in the last 10 years: ______________________________

____

3. Please describe your practice:
Sole Proprietorship (unincorporated) ______________________________
Professional Corporation ______________________ Applicant's % Ownership: _____%
Employee, Associate, or Independent Contractor with ______________________________

4: Hours per week you practice chiropractic: ________ How many patient vistis annually: __________

5. Please indicate those procedures or devices used in your practice:

General meric adjusting	______	Cold laser	______	Stressology	______
Upper cervical specific	______	Activator	______	Internalcoccyx adjustment	______
Instrumental adjusting	______	Galvanci	______	Gemstone therapy	______
Gonstead/diversified	______	Ultraviolet	______	Toftness device	______
Direct non-force	______	Ultrasound	______	Colonic irrigations	______
Sacro-occipital	______	Massages	______	Treat cancer	______
Hydroculator/heat packs	______	Short wave diathermy	______	Treat epilepsy	______
Electrical stimulation	______	Kinesiology	______	MUA's	______
Ice-cryotherapy	______	Mechanical traction	______	Mechanical traction	______
Trigger point therapy	______	Whirlpool	______	WhirlpoolPrenatal care & normal deliveries	______

6. If the answer to any of the questions below is "no," please attach details. Do you:
a. Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? Yes or No
If no, please describe how you assess vascular flow. If an unusual finding results, do you refer the patient to the appropriate medical practitioner? Yes No

b. Make a differential diagnosis? Yes No

c. Always record the patient's account of his/her progress? Yes No

d. Always record objective findings? Yes No

e. Always record details of treatment procedures? Yes No

7: If the answer to any of the questions below is "yes," please attach details. Do you:

a. Perform acupuncture? Yes No If yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? Yes No

Date of last NCCA exam taken and passed __________ If no, do you use disposal needles? (If no, need details)

b. Dispense or prescribe: Drugs? Yes No Vitamins? Yes No

c. Use x-ray or imaging in treatment determination? Yes No

d. Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? Yes No

e. Perform investigation or experimental research or therapy on human patients? Yes No

f. Perform animal chiropractic? Yes No

8. Are you engaged in any business other than the practice of chiropractic? Yes No
If yes, please attach details.

9. Do you own (wholly or in part), operate or administer any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered? Yes No

10. Do you, or the corporation contract to provide professional services to any individual, entity or governmental entity? Yes No If yes, please attach details.

11. Are you affiliated with any hospitals? Yes No If yes, please provide name(s), city, state ______________

PRIOR POLICY AND LOSS INFORMATION – Questions 12-34 provide details for all "YES" answers

12. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? Yes No

13. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? Yes No

14. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? Yes No

15. Have you ever been charged with, or convicted of a crime other than minor traffic violations? Yes No

16. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes No

17. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? Yes No

8. Provide the following information on your past 5 years of professional liability insurance coverage:

Carrier	Policy Period	Policy Limits	Deductible	Claims Made? (Y/N)	Retro Date

19. Have you ever practiced without professional liability insurance? Yes No

20. Do you have professional liability insurance for work you do elsewhere? If yes, please explain Yes No

21. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? Yes No

22. Have you ever been involved in any professionalliability claim or suit, either directly or indirectly? Yes No

23. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? Yes No

24. Are you aware of any request for medicalrecords by a patient or his/her attorney which might result in a claim? Yes No

25. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? Yes No

26. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? Yes No NA

Indicate N/A if you are not aware of any such circumstances . If yes, how many? ____ please complete a supplemental claims form for each.

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

1) I have no known losses or claims that have not been reported to my prior insuracne carrier or any other source from which payment might be made.
2) I have no knowledge of act, omissions or circumstances that relate to a professional service which could resonably result in a claim, that has not been reported to a prior insurance carrier
3) I have no knowledge of any request fro medical records by a patient or their attorny which might result in a claim
4) I have no knowledge or information realting to service or services on a Board which might resuly in a claim
5)I have no knowledge of any prior professional liability carrier refusing for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, thret of claim, letter of intent, adverse result or attorney contact.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material fact. The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.
All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ______________________ Title: ______________________

Applicants Signature: ______________________ Date: ______________________

Agent/Broker Name: ______________________________________