american naturopathic council member application

Contact and Practice Information:

Full Name (First, Middle, Last)	Practice / Clinic Name
Office Address (include Suite #)	City / State / Zip
Mailing Address – If Different from Office Address	City / State / Zip
Office Phone / Alternate Phone (Home, Cell, etc.) / Fax	Email
Naturopath License Number(s) / State Issued / Date Issued	Naturopath College and Location / Year Graduated
Social Security Number / Birth Date	Gender: ❒ Male ❒ Female

Fax or Mail Completed Application and Payment to:

SCOTT DANAHY NAYLON
INSURANCE BROKERS

300 Spindrift Drive
Amherst, NY 14221
www.scottdanahynaylon.com
Phone: (800) 728-6362 / 716-633-3400
FAX: 716-633-7141

Payment Detail (See "Rate Sheet" for coverage choices)**:**

Installment Due: ________________

____

Optional Additional Insured (10% per Add Ins.) ________________

Total Payment Remitted ________________

Credit Card Payments, Complete Following:

Card Type: ❒ Visa ❒ MasterCard ❒ American Express

Card #: ____________________

Expires: ____________________

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the American Naturopathic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: ____________________

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Membership Application

Professional Information

1. Is your naturopathic license current? ☐Yes ☐No
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees; or In the last three years has anyone asserted that your care, treatment or diagnosis was deficient or caused them harm? (If *Yes*, explain) ☐Yes ☐No
3. Has any agency or association ever investigated or taken any action against you or your license? (If *Yes*, explain) ☐Yes ☐No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If *Yes*, explain) ☐Yes ☐No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If *Yes*, explain) ☐Yes ☐No
6. Have you been convicted of violating any law other than a minor traffic offense? (If *Yes*, explain) ☐Yes ☐No
7. Do you treat cancer or epilepsy? (If *Yes*, explain) ☐Yes ☐No
8. Do you use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness device? (If *Yes*, explain) ☐Yes ☐No
9. Do you use any technique or therapy not taught in the naturopathic schools and colleges? (If *Yes*, explain) ☐Yes ☐No
10. Do you ever collect fees for services before the day on which you provide those services? (If *Yes*, explain) ☐Yes ☐No
11. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *Yes*, explain) ☐Yes ☐No
12. Have you ever treated a person that was previously in a research program you sponsored? (If *Yes*, explain) ☐Yes ☐No
13. Have you used a practice management company? ☐Yes ☐No IF *Yes*, provide name: ____________________
14. Standard Modalities - Check each of the following treatment modalities you have used, or intend to use in your practice:

☐ Acupuncture [a]	☐ Diathermy	☐ Nutritional Therapy	☐ Ultrasound
☐ Behavioral [b]	☐ Electrical Stimulation	☐ Paracentesis	☐ Weight Control [c]
☐ Bio Feedback	☐ Homeopathy	☐ Physical Therapy	
☐ Botanical / Herbal Medicine	☐ Manipulation Therapy [a]	☐ Thoracentesis	

a *– A separate application addendum is required if you desire coverage to extend to either acupuncture or manipulation under anesthesia. Please request.*

15. Class II or Class III Modalities: Check any or all treatment modalities you have used, or intend to use in your practice:

☐ Cheletion Therapy (II or III)	☐ Hypnosis (III)	☐ Obstetrics / Deliveries (III)	☐ Prolo / Sclero Therapy (III)
☐ Colonoscopy (II)	☐ Needle Biopsies (II)	☐ Office surgery (II or III)	☐ Experimental/Other Therapy (II or III)
☐ Gynecology (II or III)	☐ Neonatal/Prenatal Care (II or III)	☐ Prescription Drugs (II or III)	

A separate application addendum must be completed and approved in order for coverage to extend to any Class II or Class III modalities. If applicable, please request an addendum promptly.

16. Do you use any technique or therapy not taught in the naturopathic schools and colleges? (If *YES*, attach explanation) ☐Yes ☐No
17. Do you treat Medicaid/Medi-Cal patients? ☐Yes ☐No *If Yes*, what % of your practice is Medicaid/Medi-Cal? ____________
18. Do you make a differential diagnosis? ☐Yes ☐No *If No*, do you limit your responsibility to treating symptoms? ☐Yes ☐No
19. Do you perform cervical adjustments? ☐Yes ☐No
    If Yes, Do you always conduct comprehensive stroke screening prior to doing a cervical adjustment? ☐Yes ☐No
20. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ☐Yes ☐No
21. If the quality of an x-ray film is marginal, do you always do, or order, a retake? ☐Yes ☐No
22. Do you always require your patients to sign an informed consent prior to treatment? (If *Yes*, attach copy of form you use) ☐Yes ☐No
23. Do you always record the patient's account of his or her progress? ☐Yes ☐No ☐No, but I will do so now.

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24. Do you always record objective findings? ☐Yes ☐No ☐No, but I will do so now.

25. Do you always record details of treatment procedures? ☐Yes ☐No ☐No, but I will do so now.

21. Do you refer to other health providers? ☐Yes ☐No *If Yes*, circle: MD Ortho Neuro DC RN RPT Other: ____________

26. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): ____________

    Indicate your malpractice carrier for that other profession: ____________ Expires: ____________

27. Which best describes how you practice: ☐Sole Proprietor ☐Professional Corp. ☐Partnership ☐Employee ☐Contractor

28. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

    ____________ ____________ ____________ ____________

29. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (10% cost), or separate limit (40% cost). Add sheets as needed:

    ____________ Name of Additional Insured — Limits: ☐Shared ☐Separate
    ____________ Name of Additional Insured — Limits: ☐Shared ☐Separate

30. Who provides your current naturopath malpractice policy? ____________ Expires: ____________

31. Your Naturopath insurance, if approved, will be effective the date your app is received. For a later date, specify here: ____________

32. How many patients do you see weekly? ________ How many hours / week do you spend professionally with patients? ________

33. What is the average time you spend professionally with a patient on their first office visit? ________ Follow up visit? ________

Signatures - Member Application for Coverage *(Signatures are required in all* ***FOUR*** *places below)*

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts, and I agree that this declaration shall be a basis of the contract and form a part of my malpractice insurance policy. I understand that untrue statements could void my insurance policy.

1. Sign here: ____________________ **Date:** ____________

CLAIMS-MADE ONLY *(Applies only if you selected a "Claims Made" Claims Reporting Basis):* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. Sign here: ____________________ **Date:** ____________

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that price distinctions based on safe naturopath practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

3. Sign here: ____________________ **Date:** ____________

RELEASE OF INFORMATION: I hereby authorize release of information from my professional naturopath associations & organizations, any hospitals or insurance carriers, my State Board of Naturopath Examiners, and any other relevant entity to: the American Naturopath Council or its agent, for any underwriting or claim-related inquiry. I agree that the organization releasing such information, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

4. Sign here: ____________________ **Date:** ____________