Malpractice Policy

To be considered for coverage, please complete the attached application and forward it to:

Brian M Gallagher, Licensed Ins. Broker

Scott Danahy Naylon, LLC

300 Spindrift Drive

Amherst, New York 14221

1-800-728-6362 Ext: 5131

Fax (716) 633-4306

Email: bmgallagher@sdnins.com

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 ____

Birth Date ____ Gender: ☐ Male ☐ Female

Fax or Mail Completed App & Payment to:

SDN INSURANCE AGENCY, LLC

300 Spindrift Drive
Amherst, NY 14221
www.sdnins.com
Phone: 800-728-6362 / 716-633-3400
Fax: 716-633-4306
Email: naturo@sdnins.com

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

Installment Due: ____

Optional Additional Insured (5% 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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american naturopathic council

Membership Application

Professional Information

1. Is your naturopathic license current? ☐Yes ☐No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused 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 charged with or 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. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ☐Yes ☐No
20. If the quality of an x-ray film is marginal, do you always do, or order, a retake? ☐Yes ☐No
21. Do you <u>always</u> require your patients to sign an informed consent prior to treatment? (If *Yes*, attach copy of form you use) ☐Yes ☐No
22. Do you <u>always</u> record the patient's account of his or her progress? ☐Yes ☐No ☐No, but I will do so now.
23. Do you <u>always</u> record objective findings? ☐Yes ☐No ☐No, but I will do so now.
24. Do you <u>always</u> record details of treatment procedures? ☐Yes ☐No ☐No, but I will do so now.

american naturopathic council

Membership Application

25. When a patient needs treatment or diagnosis outside your scope of practice, do you refer them to other health providers? ☐Yes ☐No
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 (5% cost), or separate limit (20% cost). Add sheets as needed:

    ______ Limits: ☐ Shared ☐ Separate ______ Limits: ☐ Shared ☐ Separate
    Name of Additional Insured   Name of Additional Insured
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 I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my 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:** ______

American Naturopathic Council Application Addendum

Supplemental Professional Information

If you selected any of the items listed in Question 15 of your application, you should complete this addendum. Review the modalities listed below. Place a check mark ☑ next to each modality you are using or intend to use, then complete the requested information. If you have not used a modality yet, answer questions based on how you intend to integrate that modality into your practice. Prior approval is required for coverage to extend to any of these modalities. Complete and submit this Addendum to the Company for approval.

☐ ***Cheletion Therapy*** Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ____________ # Hours: ________ Completed: ________

Describe Training: ____________
(Nature of Curriculum) ____________

Usage Indicate the *number* of times per month that you use cheletion therapy: ________ Times per Month

Do you ever do I.V. Cheletion Therapy? ☐ Yes ☐ No If *Yes*, how often: ________ Times per Month

Indicate the *percentage* of your patients with whom cheletion therapy is used: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending cheletion therapy: ____________

____

____

☐ ***Colonoscopy*** Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ____________ # Hours: ________ Completed: ________

Describe Training: ____________
(Nature of Curriculum) ____________

Usage Indicate the *number* of times per month that you perform colonoscopies: ________ Times per Month

Indicate the *percentage* of your patients for whom you perform colonoscopies: % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending a colonoscopy: ____________

____

____

____

☐ ***Gynecology*** Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ____________ # Hours: ________ Completed: ________

Describe Training: ____________
(Nature of Curriculum) ____________

Usage Indicate the *number* of times per month that you render gynecological services: ________ Times per Month

Indicate the *percentage* of patients for whom you perform gynecological procedures: ________ % of Patients

Describe the five most common gynecological services / procedures provided to patients at your office: ____________

____

____

____

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☐ *Hypnosis*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________________ # Hours: ________ Completed: ________

Describe Training: ______________________
(Nature of Curriculum) ______________________

Usage Indicate the *number* of times per month that you use hypnosis as a therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom you use hypnosis as a therapy: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending hypnosis therapy: ______________

____

____

____

☐ *Needle Biopsies*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________________ # Hours: ________ Completed: ________

Describe Training: ______________________
(Nature of Curriculum) ______________________

Usage Indicate the *number* of times per month that you use needle biopsies in diagnosis: ________ Times per Month

Indicate the *percentage* of your patients with whom you utilize needle biopsies: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to performing a needle biopsy: ______________

____

____

____

☐ *Neo Natal / Pre Natal Care*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________________ # Hours: ________ Completed: ________

Describe Training: ______________________
(Nature of Curriculum) ______________________

Usage Indicate the *number* of patients at any time actively in your Neo Natal / Pre Natal care: ________ Times per Month

Indicate the *percentage* of patients for whom you provide Neo Natal / Pre Natal care: ________ % of Patients

Do you require all Neo Natal/Pre Natal patients to be under the concurrent care of a Neo Natal / Pre Natal physician? ☐ Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient for Naturopath Neo Natal / Pre Natal care: ________

____

____

____

☐ *Obstetrics/ Deliveries*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ______________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ______________________ # Hours: ________ Completed: ________

Describe Training: ______________________
(Nature of Curriculum) ______________________

____

Usage

Indicate the *number* of times per month that you are involved with a delivery of a child: ________ Times per Month

Indicate the *percentage* of your patients who are pregnant: ________ % of Patients

Do you ever induce and / or stop labor ? ☐ Yes ☐ No If *Yes*, how often: ________ Times per Month

Do you ever render care while a woman is in labor? ☐ Yes ☐ No If *Yes*, how often: ________ Times per Month

Do you ever deliver babies? ☐ Yes ☐ No If *Yes*, how often: ________ Times per Month

Do you require all obstetrical patients to be under the concurrent care of an obstetrical medical doctor? ☐ Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient as suitable for naturopath birthing services: ________

____

____

____

☐ *Office Surgery*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ________ # Hours: ________ Completed: ________

Describe Training: ________
(Nature of Curriculum) ________

Usage

Indicate the *number* of times per month that you perform office surgery: ________ Times per Month

Indicate the *percentage* of your patients for whom you perform office surgery: ________ % of Patients

Describe the five most common surgical procedures conducted at your office: ________

____

____

____

☐ *Prescription Drugs*

Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: ________ Completed: ________

Other? (Specify where): ________ # Hours: ________ Completed: ________

Describe Training: ________
(Nature of Curriculum) ________

Usage

Indicate the *number* of times per month that you use prescription drugs: ________ Times per Month

Indicate the *percentage* of your patients for whom you prescribe prescription drugs: ________ % of Patients

For each drug you prescribe, describe 1) the indications you observe / diagnostic analysis you conduct prior to prescribing that drug, and 2) the outcome you expect from prescribing that drug:

Drug	Indications / Diagnosis	Expected Outcome

☐ ***Prolo/Sclero Therapy*** Currently Licensed / Certified?: ☐ Yes ☐ No If *Yes*, Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________ # Hours:________ Completed:________

Describe Training: ____________
(Nature of Curriculum) ____________

Usage Indicate the *number* of times per month that you use prolo / sclero therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom prolo / sclero therapy is used: ________ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending prolo / sclero therapy : ____________

____

____

____

☐ ***Other/Experimental Therapy*** Currently Licensed/Certified?: ☐ Yes ☐ No If *Yes*, Designation: ____________

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours:________ Completed:________

Other? (Specify where): ____________ # Hours:________ Completed:________

Describe Training: ____________
(Nature of Curriculum) ____________

Usage Indicate the *number* of times per month that you use some experimental therapy: ________ Times per Month

Indicate the *percentage* of your patients with whom you use some experimental therapy: ________ % of Patients

Describe the diagnostic analysis you conduct prior to recommending experimental therapy to a patient: ____________

____

____

____

Describe the three most common experimental procedures you used in your practice during the last twelve months:

____

____

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 professional liability policy. I understand that untrue statements could void my insurance policy:

____________ ____________ ____________
Print Name Signature Date

COVERAGE APPLICATION ADDENDUM

REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

NAME OF INSURED: ______________________________

OFFICE HOURS: Indicate your normal weekly office hours by day of the week:

DAY:	SUN	MON	TUE	WED	THU	FRI	SAT
HOURS:							

HOURS WORKING EACH WEEK:

How many hours per week do you spend interacting with patients, reviewing / documenting patient files, or supervising others who are working with patients or on patient files? [ ]

How many patient appointments do you typically have each week? [ ]

How much time do you typically spend for each patient visit? This includes time spent preparing for the patient visit, meeting with and treating the patient, and completing documentation regarding the patient visit? [ ]

ANNUAL VOLUME: About how many patient visits did you have last year? [ ]

CERTIFICATION: I hereby declare the above statements are true, and I have not misstated or suppressed any facts. I understand the insurance company has the right, but not the duty, to audit my books to confirm the above is true and correct. I further understand that any fraudulent or intentional misrepresentation could result in my rate being increased, coverage being canceled, and/or a claim being denied.

Signature: ______________________ Date: ______________________

Name: ______________________

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PAYMENT AUTHORIZATION

CREDIT CARD OR ACH – ONE TIME OR RECURRING PAYMENTS

When making payments with a Credit Card or ACH, use this form to set up either a one-time payment or recurring installment payments. Complete all four sections below. Sign and date where indicated to authorize payment(s).

1. **Name of Insured:** ______________________________

2. **Payment Amount and Frequency:**
   - **Amount** to be Charged or Debited: $ ______________
   - **Frequency** of Payment: ☐ Annual (One time Charge) ***or*** Installments[1] ☐ Quarterly

     1 - Quarterly requires Autopay via Credit Card or ACH.

3. **Method of Payment:** (Complete only the applicable section)
   - **Credit Card Payments:**

     Credit Card Type (select one): ☐Visa ☐MasterCard ☐American Express

     Name on Account[2]: ______________________________

     Card #: ______________________________

     Expiration: ______________

   - **ACH Payments:**

     Account Type (select one): ☐ Personal Account ☐ Business Account

     Name on Account[2]: ______________________________

     Account #: ______________________________

     Bank Name ______________________________

     Bank Routing #: ______________________________

     Branch City/State: ______________________________

     2 - If Name on Account is not the Name of the Insured, Complete Section 5, below.

4. **Payment Authorization:** I, the Authorized Signatory on the account indicated above, declare that I signed/typed my name below. You are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing.

   Authorized Signatory on Account Sign Here: ______________________________ **Date:** ______________

5. **Refunds** ***(Complete only if Name on Account is not the Named Insured)*****:** I, the Named Insured, declare that I signed/typed my name below. Should a refund be made in connection with coverage paid for as a result of this Payment Authorization Form, the refund should be issued to the person listed as the Name on Account above.

   Named Insured Sign Here: ______________________________ **Date:** ______________

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