



# 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: <input type="checkbox"/> Male <input type="checkbox"/> 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: \_\_\_\_\_

### 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:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Acupuncture <sup>a</sup>    | <input type="checkbox"/> Diathermy                         | <input type="checkbox"/> Nutritional Therapy | <input type="checkbox"/> Ultrasound                  |
| <input type="checkbox"/> Behavioral <sup>b</sup>     | <input type="checkbox"/> Electrical Stimulation            | <input type="checkbox"/> Paracentesis        | <input type="checkbox"/> Weight Control <sup>c</sup> |
| <input type="checkbox"/> Bio Feedback                | <input type="checkbox"/> Homeopathy                        | <input type="checkbox"/> Physical Therapy    |  |
| <input type="checkbox"/> Botanical / Herbal Medicine | <input type="checkbox"/> Manipulation Therapy <sup>a</sup> | <input type="checkbox"/> 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:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Cheleton Therapy (II or III) | <input type="checkbox"/> Hypnosis (III)                     | <input type="checkbox"/> Obstetrics / Deliveries (III)  | <input type="checkbox"/> Prolo / Sclero Therapy (III)           |
| <input type="checkbox"/> Colonoscopy (II)             | <input type="checkbox"/> Needle Biopsies (II)               | <input type="checkbox"/> Office surgery (II or III)     | <input type="checkbox"/> Experimental/Other Therapy (II or III) |
| <input type="checkbox"/> Gynecology (II or III)       | <input type="checkbox"/> Neonatal/Prenatal Care (II or III) | <input type="checkbox"/> 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 always require your patients to sign an informed consent prior to treatment? (If Yes, attach copy of form you use)  Yes  No
22. Do you always record the patient's account of his or her progress?  Yes  No  No, but I will do so now.
23. Do you always record objective findings?  Yes  No  No, but I will do so now.
24. Do you always record details of treatment procedures?  Yes  No  No, but I will do so now.

## 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:  
\_\_\_\_\_  
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 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: \_\_\_\_\_