



PROFESSIONAL LIABILITY APPLICATION FOR MENTAL HEALTH COUNSELING SERVICES / CLINICS

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.

If the answer is NONE, state NONE;

If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).

If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.

NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (____) _____ Fax (____) _____

1.6 Person to contact for Survey: Name: _____ Title: _____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) of B) below:

A. The **APPLICANT** is an INDIVIDUAL. If so, the INDIVIDUAL is an:

Employee (W-2) Student Ind. Contr. (1099) Sole Practitioner

B. The **APPLICANT** is a:

Sole Proprietorship Partnership Corporation

Other - Describe: _____

1.9 Entity is For Profit Non-Profit, Describe source of funds: _____

1.10 Proposed Effective Date: _____

1.11 Requested Limits of Liability (if available): \$ _____

Is General Liability coverage also desired? No Yes

1.12 Annual Gross Receipts: Estimated next twelve months - \$ _____

Last twelve months - \$ _____

1.13 Number of Patient Encounters: Next 12 months: _____ Last 12 months _____

1.14 Premises Square Footage Area occupied by applicant: _____

Are any off premises services provided? If yes, describe: _____

PART II. EXPOSURES

- 2.1 Service is licensed as _____
- 2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _____
- 2.3 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction. _____
- 2.4 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration, or more than 25 patients/clients any one occasion? ___ No ___ Yes IF YES, give frequency and length of sessions, and # patients/clients: _____ (b) Does applicant conduct any seminars, workshops or other "group activities" away from regular office premises (including teaching seminars for fellow professionals) ___ No ___ Yes IF YES, give frequency of seminars and # participants/attendees. _____
- 2.5 Does applicant sell, rent or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.) ___ No ___ Yes IF YES, describe and give est. receipts. _____
- 2.6 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients.
- A) Hypno Therapy
___ No
___ Yes If yes, ___%
 - B) Biofeedback
___ No
___ Yes If yes, ___%
 - C) Kinesthetics
___ No
___ Yes If yes, ___%
 - D) Psychodrama
___ No
___ Yes If yes, ___%
 - E) Bioenergetics
___ No
___ Yes If yes, ___%
- 2.7 Does applicant routinely (more than twice in last three years) provide testimony in:
- 1) Child custody hearing ___ No ___ Yes If Yes, # times 3 yrs _____
 - 2) Competency hearings ___ No ___ Yes If Yes, # times 3 yrs _____
 - 3) As an expert witness in criminal or civil trials or other legal proceeding
___ No ___ Yes If Yes, # times 3 yrs _____
- 2.8 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying or apprehending criminal offenders? ___ No ___ Yes
IF YES, describe and give frequency _____
- 2.9 Does applicant's practice involve the following: **If Yes, give % of practice**, by income, hours or # clients.
- Child/pediatric therapy
___ No ___ Yes If yes, ___%
 - Criminal offender therapy/evaluation
___ No ___ Yes If yes, ___%
 - Therapy for victims of criminal sexual abuse
___ No ___ Yes If yes, ___%
 - Therapy for substance abusers
___ No ___ Yes If yes, ___%
 - Crisis Intervention
___ No ___ Yes If yes, ___%
 - Therapy for sexual response/dysfunction
___ No ___ Yes If Yes, ___%

- 2.10 Does applicant's practice involve the following: If YES, give % of practice, and number of clients treated in the last three years. Diagnosis / treatment of:
 "Failed/Repressed" Memory Syndrome ___ No ___ Yes If Yes, ___% # clients 3 yrs
 Multiple Personality Disorder ___ No ___ Yes If Yes, ___% # clients 3 yrs
- 2.11 Are any of applicant's patients/clients referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client? ___ No ___ Yes IF YES, give % of patients. _____
- 2.12 **Unless otherwise noted hereunder**, the following are true statements with regard to the applicant:
- a) Applicant, including employees and independent contractor, is not a principal with any healthcare related partnership, association or corporation, nor is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees, or governors of any healthcare related business enterprise;
 - b) Applicant does not provide billing or collection services for any other professional person or organization;
 - c) Applicant does not share staff with any other professional person or organization;
 - d) Applicant does not share office premises with any psychiatrist or any other physician;
 - e) Applicant, including employees and independent contractors, is not licensed or authorized to provide any other professional services except as stated in application;
 - f) Applicant, including employees and independent contractors, has never had his/her license or certification revoked or suspended, not been the subject of any disciplinary proceeding, not been reprimanded by an administrative agency, professional association or peer committee;
 - g) Applicant, including employees and independent contractors has never had a claim or suit brought against him/her because of any alleged malpractice, error or mistake arising out of his/her professional services, and applicant is not aware of any circumstances which might result in such a claim or suit.
- EXCEPTIONS**, if any, to above (absence of entry means "no exceptions"): _____

PART III. RISK MANAGEMENT

- 3.1 Please list all professional staff including degrees held, professional designation:
- a) Salaried Employees (W-2) _____

 - b) Independent Contractors (1099) _____

 - d) Professional Associates Sharing Premises _____

- 3.2 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ___ No ___ Yes
 If no, do you require contracted staff (if any) to carry their own Professional Liability Insurance?
 ___ No ___ Yes
 Do you secure Certificates of Insurance as evidence of such coverage?
 ___ No ___ Yes
- 3.3 List all memberships in professional organizations. _____

- 3.4 Do you enter into contractual agreements to provide professional services?
 ___ No ___ Yes
 IF YES, enclose copies of all such contracts.
 Do you provide services under contract, with said services billed by the other party in lieu of you billing direct for your services? ___ No ___ Yes If Yes, identify contract and services provided:

- 3.5 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you?
 ___ No ___ Yes
 If not, are you agreeable to instituting this procedure?
 ___ No ___ Yes
- ENCLOSE COPY OF YOUR LETTERHEAD, BROCHURES, ADVERTISING.**

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, with the most recent year. If none, so state.

| Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Form | |
|----------|---------------|---------------------|---------|-----------|------------------|-----|
| | | | | | No | Yes |
| 1. _____ | | | | | | |
| 2. _____ | | | | | | |
| 3. _____ | | | | | | |
| 4. _____ | | | | | | |
| 5. _____ | | | | | | |

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, with the most recent year. If none, so state.

| Insurer | Policy Number | Liability | Premium | Limits of Eff. Date | Claims-Made Form | |
|----------|---------------|-----------|---------|---------------------|------------------|-----|
| | | | | | No | Yes |
| 1. _____ | | | | | | |
| 2. _____ | | | | | | |
| 3. _____ | | | | | | |
| 4. _____ | | | | | | |
| 5. _____ | | | | | | |

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

___ No ___ Yes
 IF YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

___ No ___ Yes
 IF YES, describe the event and indicate the reason for anticipation of a claim. _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title



DRUG AND SUBSTANCE ABUSE TESTING SUPPLEMENTAL QUESTIONNAIRE

1. Type specimens taken / tested:

_____ Urine _____ Blood

_____ Other: Describe _____

2. Who does testing?

_____ Insured's own laboratory / staff

_____ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead results are sent out on)

_____ Independent Laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead results sent out on)

3. Describe exactly who reads and interprets the test results:

4. Describe the "protocols" in place to prevent reporting of "false positive" results:

5. Describe the "policy" regarding "confidentially" of reports and records.

6. In the past year:

(a) How many positive test results? _____

(b) How many employees:

(1) treated? _____

(2) counseled? _____

(3) terminated from employment? _____

7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, include brochure if available.

8. Enclose copies of contracts between Insured and Client companies.

ADDENDUM TO MENTAL HEALTH PRACTITIONER'S APPLICATION

SUPERVISION OF OTHERS

Named Insured: _____

Fully describe the scope of your responsibilities as a **supervisor**, including the percentage of your time spent in this capacity.

| |
|--|
| |
| |
| |

Please provide the following information for each individual supervised:

| NAME | POSITION | HOURS PER WEEK | COMPENSATED (Yes/No) | INSURED* (Yes/No) | # CONTACTS/WK |
|--|----------|-------------------|-------------------------|----------------------|---------------|
| | | | | | |
| | | | | | |
| How are supervisee's hours billed to the client/patient? | | | | | |
| How does supervisee's patient profile differ from yours? | | | | | |
| Explain circumstances if supervisee is seeing patients away from your workplace. | | | | | |
| | | | | | |

* If insured, attach certificate of insurance.