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|---|---|---|
| JAMES RIVER INSURANCE | **James River Insurance Company and its Subsidiaries**<br>6641 West Broad Street, Suite 300<br>Richmond, VA 23230 | **Medical Clinic & Outpatient Rehabilitation Application – Claims Made Professional**<br>**ALLIED HEALTHCARE Division**<br>Email to AH@jamesriverins.com or,<br>Fax to 804-420-1054 |

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

# MEDICAL CLINIC AND OUTPATIENT REHABILITATION APPLICATION

1. Applicant's Facilities Name: _____

2. Mailing Address: _____
   Street City County State Zip

3. Primary Location Address: _____
   Street City County State Zip

4. List all Locations where Applicant is registered and licensed to operate:
   1. _____
   2. _____
   3. _____

   (Attach Additional Pages as needed)

5. Applicant is a: ☐ Sole Proprietorship ☐ LLC ☐ Corporation ☐ Joint Venture ☐ Partnership ☐ Other (please explain)_____

6. Applicant is: ☐ For Profit ☐ Not for Profit 7) Number of years in operation: _____

8. Days/Hours of operation: _____ 9) Business Website: _____

10. Description of Operations : _____

11. List all accreditations and include copy of report:
    ☐ AAUCM ☐ UCAOA ☐ JCAHO ☐ Other (please explain)_____ ☐ AAAHC

12. Revenue (Applicant's Gross Revenue)
    Last 12 Months $_____
    Next 12 Months $_____

 

13. Outpatient Visits:

| | Number of Outpatient Visits (OPVs) | | |
|---|---|---|---|
| | **Prior Year 20__** | **Current 20__** | **Projected 12 Months** |
| General Practice/Family Medicine – to include after hours non-emergent visits – No Surgery | | | |
| Gynecological including office gynecology | | | |
| Obstetrics including prenatal care *(answer question 13)* | | | |
| Urgent/Emergency Care | | | |
| Optometry | | | |
| Dialysis | | | |
| Psychiatric/Mental Health | | | |
| Crisis Stabilization | | | |
| Holistic | | | |
| Dental | | | |
| Lithotripsy | | | |
| Family Planning | | | |
| Substance Abuse – skilled medicine (detox) | | | |
| Substance Abuse – therapy | | | |
| Brain or spinal injury rehabilitation | | | |
| Cardiac Rehabilitation | | | |
| Physical/occupational rehabilitation – skilled medicine | | | |
| Physical/occupational rehabilitation – therapy | | | |
| Other: | | | |
| Other: | | | |
| TOTAL: | | | |

14. With regard to obstetrics please advise to the extent of care rendered to patients. Please check all that apply. (Skip this question if no obstetrical care is rendered.)

☐ Prenatal Care - 1st Trimester
☐ Prenatal Care - 2nd Trimester
☐ Prenatal Care - 3rd Trimester
☐ Delivery ☐ At Hospital ☐ At Clinic

15. Does the applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No

16. Are any of the following procedures performed at the clinic?

a) Abortions ☐ Yes ☐ No If "Yes" please complete abortion supplement
b) Closed Reduction of Fractures ☐ Yes ☐ No If "Yes" please advise as to the number annually _____
c) Anti-aging or Esthetic procedures (including but not limited to Botox, Resytlane, or Laser Hair removal) ☐ Yes ☐ No If "YES" please complete Medical Spa supplement
d) Bariatric Medicine ☐ Yes ☐ No If "Yes" please complete Bariatric supplement
e) Methadone Maintenance / Treatment ☐ Yes ☐ No If "Yes" please complete Methadone Supplement
f) Electroconvulsive therapy **(**ECT) ☐ Yes ☐ No If "Yes" please advise as to the number of annual treatments_____. Any treatment of

 

minors with ECT? ☐ Yes ☐ No

g) Chemotherapy ☐ Yes ☐ No

h) Sterilization Procedures ☐ Yes ☐ No

(I) Any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? If yes please note all such procedures below unless otherwise addressed in items A-H above

Are any experimental procedures, clinical trials or off-label equipment or medications used at the clinic? ☐ Yes ☐ No

17. Is anesthesia administered at the facility? (check all that apply)

☐ None

☐ Local or topical anesthesia

☐ Local or topical anesthesia and/or intravenous or parenteral sedation, regional anesthesia or other analgesia or anesthesia, without the use of: endotracheal or laryngeal mask intubation or inhalation general anesthesia (e.g., nitrous oxide)?

☐ Other types of anesthesia, including any use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (e.g., nitrous oxide)?

18. Is anesthesia provided by a contracted service or provider(s)? If a contracted service and/or provider provides anesthesia, are limits of 1M/3M required of the service/provider(s)? ☐ Yes ☐ No

19. Are all CRNAs supervised by anesthesiologists?

20. Does the clinic have any of the following on site services?

RADIOLOGY

- Ultrasound ☐ Yes ☐ No
- Computer Tomography ☐ Yes ☐ No
- Magnetic Resonance Imaging ☐ Yes ☐ No
- Nuclear Medicine ☐ Yes ☐ No
- X-ray ☐ Yes ☐ No

PHARMACY

- Including Compounding ☐ Yes ☐ No
- **Not** Including Compounding ☐ Yes ☐ No

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Are any of the above services offered on a stand alone basis to non-clinic patients? ☐ Yes ☐ No

 

21. Do all locations have written procedures for the following

a. Patient Intake, including verification of contact information? ☐ Yes ☐ No

b. Informed consent to treatment, including risks associated with refusal? ☐ Yes ☐ No

c. Treatment of chest pain and respiratory ailments? ☐ Yes ☐ No

d. Patients receiving written, individualized discharge instructions which detail emergency care procedures? ☐ Yes ☐ No

e. Follow up policies that address the following:

i. criteria for when follow-up is required of patient ☐ Yes ☐ No
ii. specific time-frames ☐ Yes ☐ No
iii. documentation ☐ Yes ☐ No
iv. tickler system ☐ Yes ☐ No

**PROFESSIONAL STAFF**

| | # of Employees | # of Independent Contractors | # of Volunteers | Is Coverage Desired? | **Are they insured elsewhere? If yes at what limits?** |
|---|---|---|---|---|---|
| Physicians: No surgery (other than incision of boils, suturing of skin)* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Physicians: Minor surgery * | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Anesthesiologists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Obstetrics-Gynecologists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Ophthalmologists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Urologists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Dentists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Chiropractors* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Nurse Anesthetists (CRNA)* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Nurse Practitioners* | | | | ☐ Yes | ☐ Yes ☐ No _____ |

 

| | # of Employees | # of Independent Contractors | # of Volunteers | Is Coverage Desired? | **Are they insured elsewhere? If yes at what limits?** |
|---|---|---|---|---|---|
| Optometrists | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Pharmacists | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Physician Assistants* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Podiatrists* | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Psychologists | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| RNs/LPNs/LVNs | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Social Workers | | | | ☐ Yes | ☐ Yes ☐ No _____ |
| Other(describe): _____ | | | | ☐ Yes | ☐ Yes ☐ No _____ |

*** If coverage is desired a supplemental application must be submitted and an additional charge will be applied**

22. Are all of the above individuals licensed in accordance with applicable state and federal regulation? If No, please explain on page 6 ☐ Yes ☐ No

23. Please Indicate all of the hiring/ screening procedures used for professionals and paraprofessionals who provide patient care services at your facility (check all that apply).

☐ Check of educational background, or residency program, when applicable

☐ Criminal Background Checks

☐ Check of previous employers

☐ Verify pending license suspensions or revocations, or pending disciplinary actions by other facilities

☐ Review/approval of requested privileges by the clinic's medical director and/or credentials committee?

☐ A formal process for assuring that physicians maintain matching or greater insurance limits as the facility?

**IV. CLAIMS AND HISTORY:**

24. Has the applicant or any of its employees ever: **(Please explain all "yes"** ☐ Yes ☐ No

 

**answers on page 8)**

(a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative, or governmental agency?

(b) Been convicted for an act committed in violation of any law or ordinance?

(c) Been evaluated or treated for alcoholism or drug addiction or mental or emotional illness?

(d) Had any accreditation, professional license, or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license?

25. Has any claim or suit for malpractice or general liability ever been made against the Applicant or any person proposed for this insurance? ☐ Yes ☐ No
**If "yes" how many? _____ (complete a supplemental form for each, page 8)**

26. Has any claim or suit for malpractice or general liability ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If "yes" please explain on page 8** ☐ Yes ☐ No

27. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice or general liability claim or suit? ☐ Yes ☐ No
**If "Yes" how many? _____ (complete a supplemental form for each, page 8)**

28. Has any prior professional liability or general liability company refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No
**If "yes" please explain on page 8.**

**V. PRIOR COVERAGE**

**PROFESSIONAL LIABILTY -** Check Here if None ☐

| Company | Each Claim Limit | Aggregate Limit | Policy Dates From | To | Claims Made or Occurrence ? | Retroactive Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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**GENERAL LIABILITY -** Check Here if None ☐

| Company | Each Claim Limit | Aggregate Limit | Policy Dates From | To | Claims Made or Occurrence ? | Retroactive Date |
|---|---|---|---|---|---|---|
| | | | | | | |

 

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**VI. GENERAL LIABILITY** (Questions 29-33 only to be completed by the Applicant if applying for General Liability)

29. Complete the following for each of the Applicant's locations:

| | Location 1 | Location 2 | Location 3 | Location 4 |
|---|---|---|---|---|
| Square Footage | | | | |
| Year Built | | | | |
| Year Remodeled | | | | |
| Number of Stories | | | | |
| Type of Construction (frame, brick, concrete) | | | | |
| % of Building Occupied | | | | |
| Other occupants? (Yes/No) | | | | |

30. Are all of the Applicant's locations equipped with:

a. Complete Sprinkler System? ☐ Yes ☐ No

b. At least two clearly marked exits on each floor? ☐ Yes ☐ No

c. Self-closing fire doors on each floor? ☐ Yes ☐ No

d. Automatic fire alarm system connected to a local fire department? ☐ Yes ☐ No

e. Smoke detectors? ☐ Yes ☐ No

f. Posted emergency evacuation procedures? ☐ Yes ☐ No

g. Properly maintained fire extinguishers? ☐ Yes ☐ No

31. Does the Applicant have a written safety program in place? If yes, please provide a copy. ☐ Yes ☐ No

32. Do any of the Applicant's locations have any: (if Yes please explain below)

a. Exposure to flammables, explosive, chemicals? ☐ Yes ☐ No

b. Exposure to radioactive materials? ☐ Yes ☐ No

 

## SUPPLEMENTAL INFORMATION

***Please use this form to provide additional information or to answer any questions.***

| Question No. | |
|---|---|
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**NOTICE TO APPLICANT**: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or “CLAIMS MADE AND REPORTED” basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an “OCCURRENCE” basis, the policy provides coverage only for those occurrences that take place during the policy period. The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

**In New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**In all other states**: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

**WARRANTY**: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

| Applicant’s Name: | Signature: |
|---|---|
| Title: | Date: |

 

## SUPPLEMENTAL CLAIM INFORMATION

**If reporting more than one claim, please photocopy this form, and complete a separate form for each claim.**

**If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).**

1. Patient's Name:_____Age_____Sex_____
2. Date reported to insurance company: _____
3. Date of incident and your treatment: _____
4. Name of insurance company:_____
5. Allegations:_____

   _____

   _____
6. What is the present condition of the patient?_____

   _____
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No
8. Status of claim (check applicable answer):

| | | |
|---|---|---|
| ☐ Suit threatened, no action taken<br>☐ Suit filed but dropped by claimant<br>☐ Summary judgment in your favor | Court outcome in your favor:<br>☐ Jury verdict<br>☐ Directed verdict | Unresolved/Open Claim:<br>☐ Awaiting mediation<br>☐ Awaiting court action |
| ☐ Suit settled out of court<br>a. Date claim paid:_____<br>b. Amount paid: $ _____<br>c. Did you want to settle this claim? ☐ Yes ☐ No | Court outcome in favor of plaintiff:<br>☐ Jury verdict<br>☐ Directed verdict<br>Amount of loss payment:<br>$ _____ | Reserve Amount:<br>$_____ |

9. Name and address of the attorney assigned to your case:_____

   _____
10. To your knowledge, was any settlement paid by another party involved (your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No

    If yes, what was the amount of the settlement? _____
11. Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:_____

    _____

    _____

    _____

Applicant's Signature _____ Date: _____

Name (Printed) _____

 

 