

**AMBULATORY SURGICAL CENTERS
PROFESSIONAL AND GENERAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired: _____

I. GENERAL INFORMATION:

1. Complete name of facility (applicant) (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary)**: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Contact name: _____ Title: _____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

List all other locations **(use an additional sheet of paper if necessary)**: _____

2. In what state is the facility domiciled? _____

3. Applicant is: a. Individual Partnership Corporation Professional Association Other: _____
b. Not-for-profit For-profit Both

4. Date established: _____ / _____

5. List all states where you are licensed to practice: _____

6. Current accreditations or associations: NAHC TAHC JCAHO CHAP NHPCO Other: _____

7. Is the firm engaged in, owned by or associated with or controlled by any other business? Yes No
If yes, give details (use an additional sheet of paper if necessary): _____

8. Please list the individual shareholders or partners of the facility: _____

II. OPERATIONS:

1. a. Your professional specialty: _____

- b. Do you maintain any beds for overnight occupancy? Yes No
If yes, please explain. _____

- c. Indicate three (3) largest (patient volume) departments by specialty.
- (i) _____ approximate percentage to total volume _____ %
- (ii) _____ approximate percentage to total volume _____ %
- (iii) _____ approximate percentage to total volume _____ %
- d. Number of Minor Surgical Procedures performed: _____
 Number of Major Surgical Procedures performed: _____
- e. Do you have the following equipment at the center? Yes No
- Laboratory, with the following capabilities -- CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine? Yes No
- X-ray with on-premises processing? Yes No
- EKG -- 12 lead? Yes No
- Monitor/Defibrillator? Yes No
- Crash cart with full cardiac life support capabilities and necessary intravenous fluids? Yes No
- Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage? Yes No
- Oxygen? Yes No
- Suction? Yes No
- Pneumatic anti-shock trousers? Yes No
- Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS? Yes No
- f. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
- If Yes,
 Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 (HIPAA) Privacy Rule?
 Provide the name and title of the Applicant's Privacy Officer. _____

III. PROCEDURES:

- a. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? If yes, please attach detailed explanation of this activity? Yes No
- b. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? Yes No
 If yes, please attach a copy of ALL of the advertisements.
- c. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? Yes No
 If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- d. Do you maintain adequate medical records for each patient? Yes No
- (i) How often and by whom are the medical records reviewed? _____

- (ii) What arrangements are made for transmitting medical records to other requesting physicians?

- e. Please give names and locations of any hospitals or institutions that you use in practice.

- f. Please describe in detail your role and function in the local emergency medical services system, including:
- (i) Time and distance from the center to the nearest appropriate hospital. _____
- (ii) Physician direction and supervision of personnel, facilities, and equipment for the provision of medical services under emergency conditions. _____

IV. INTERNAL PROCEDURES

1. **Is anesthesia used?** Yes No

If yes, answer the following questions:

- a. Type of anesthesia used? _____
- b. Who administers anesthesia? _____
- c. What monitoring equipment is used for anesthesia administration? _____
- d. Is there a crash cart on the premises? Yes No
- e. What is the distance to the nearest hospital in the event of an emergency? _____
- f. How long are patients kept after the surgery/procedure? _____
- g. Who monitors patients during recovery? _____

Are patients ever kept overnight? Yes No

Are signed patient consent forms required for the following:

- a. Admission? Yes No N/A
- b. Surgery? Yes No N/A
- c. Against medical advice? Yes No N/A
- d. Any other medical treatment or dispensing of drugs? Yes No N/A

Do records reflect that the patient was advised of surgical procedures and possible risks associated with such procedures (informed consent)? Yes No N/A

Are written post-operative orders submitted and signed by the surgeon? Yes No N/A

Are sponge, needle and instrument counts performed before and after surgery? Yes No N/A

Are nursing charts maintained, including patient's condition at discharge? Yes No N/A

V. STAFF PRIVILEGES:

Are credentials for new staff members checked and approved prior to granting staff privileges? Yes No N/A

By whom? _____

Staff member's Medical Professional Liability Insurance:

- a. Are all medical staff members/independent contractors required to maintain Medical Professional Liability Insurance? Yes No
- b. What limits are required? _____
- c. What evidence of compliance is required? Yes No
Do you check on hospital privileges for physicians and dentists?

VI. SERVICES:

a. Does the applicant provide medical services for other than fee for service? Yes No

If yes, give details or arrangements, including copy of contract(s).

What is patient mix? Fee for service: _____ % Prepaid: _____ %

Percent of prepaid patients referred to outside physicians: _____ %

b. Does applicant attract patients because of reputation in any particular field of medicine? Yes No

If yes, in which field? _____

c. Indicate percentage elective surgery _____ % Non-elective _____ %

d. Do you perform hospital emergency room care for patients not your own? Yes No

b. Does applicant attract patients because of reputation in any particular field of medicine? Yes No

If yes, please attach explanation and advise the number of "patient contact" hours MONTHLY by your:

Emergency Room Physicians _____ hrs. Nurses _____ hrs.

Paramedics _____ hrs. Other _____ hrs.

- e. Do you use drugs for weight reduction of patients? Yes No
 If yes, attach list of drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed.
- f. Number of annual X-ray exposures: for diagnosis _____; for treatment _____.
- g. If X-ray treatment is given, what qualifications are required of the staff? _____
- h. Do you administer any methadone treatment? Yes No
 If yes, please attach description of treatment and controls used and indicate the number of treatments during:
 Last 12 months _____ Next 12 months _____

VII. STAFF:

- a. Do you have any restricted licensed physicians on staff? Yes No
 If yes, please explain. _____
- b. Do you have any physicians on staff that do not maintain staff privileges at a hospital? Yes No
 If yes, please explain. _____
- c. Please describe peer review process for surgeons. _____
- d. Does the center require Certificates of Insurance from all staff doctors? Yes No
 If yes, what are minimum limits of liability that are required? _____ (per claim) _____ (aggregate)
- e. Hours of operation: _____
- f. Do you have qualified physician(s) and other personnel trained in emergency medical care in center during all hours of operation? Yes No
 Please describe. _____
- g. Please indicate the number of professional employees, volunteers and independent contractors.
 IF NONE, PLEASE STATE NONE.

	No of Employees And Volunteers	No. of Independent Contractors
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures:	(i) _____	_____
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery:	(ii) _____	_____
(iii) Proctologists, Ophthalmologists and Urologists:	(iii) _____	_____
(iv) General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery):	(iv) _____	_____
(v) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery:	(v) _____	_____
(vi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons:	(vi) _____	_____
(vii) Physicians' & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet):	(vii) _____	_____
(viii) Interns/residents:	(viii) _____	_____
(ix) Unlicensed Interns:	(ix) _____	_____
(x) Dentists (no oral surgery):	(x) _____	_____
(xi) Orthodontists:	(xi) _____	_____

	No of Employees And Volunteers	No. of Independent Contractors
(xii) Oral Surgeons:	(xii) _____	_____
(xiii) Nurse Anesthetists:	(xiii) _____	_____
(xiv) Optometrists, Opticians:	(xiv) _____	_____
(xv) Pharmacists:	(xv) _____	_____
(xvi) Perfusionists:	(xvi) _____	_____
(xvii) Podiatrists:	(xvii) _____	_____
(xviii) Chiropractors:	(xviii) _____	_____
(xix) RNs, LPNs:	(xix) _____	_____
(xx) X-ray Technician:	(xx) _____	_____
(xxi) Physical therapist/pulmonary therapists:	(xxi) _____	_____
(xxii) Other miscellaneous medical personnel; (please specify and attach a list):	(xxii) _____	_____

- h. Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes No
If no, please attach explanation.
- i. Do you supervise any individuals other than your own employees? Yes No
If yes, please attach explanation of responsibilities and relationship to the entity which employs these individuals.
Please indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

29. Do you currently carry the following:

- a. **Professional Liability Insurance?** Yes No
List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

- b. **Commercial General Liability Insurance?** Yes No
If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

VIII. CLAIMS HISTORY:

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? Yes No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS OR COMPLETE THE ATTACHED CLAIM SUPPLEMENT FOR EACH CLAIM

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No
If yes, provide full details. _____
- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? Yes No
If yes, fully describe the circumstances and follow up action taken: _____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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 CONTAINING 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.

*Notice applicable in most states:

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature

Title

Date

PLEASE FURNISH THE FOLLOWING ADDITIONAL INFORMATION:

- a. A copy of your letterhead/business stationery.
- b. A copy of your protocol(s) for stabilization and transportation of patients requiring hospital or other care unavailable at the center.
- c. List of all surgical procedures performed at the center.
- d. List of activities/procedures performed, not otherwise described in this application.