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**ASBP EXCLUSIVE PREFERRED PROVIDER - BARIATRIC CLINIC**  
**(Professional Liability - Claims Made Coverage)**

**1. APPLICANT INFORMATION**

- a. Full name of Applicant (Entity Name): \_\_\_\_\_
- b. Principal business premise address: \_\_\_\_\_  
 (Street)  
 \_\_\_\_\_  
 (City) (State) (Zip)
- c. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- d. Email: \_\_\_\_\_ Website: \_\_\_\_\_
- e.  Professional Corporation (For Profit)  Partnership  
 Professional Corporation (Non-Profit)  Professional Association  
 Other (Describe) \_\_\_\_\_
- e. Date Established: \_\_\_\_\_
- f. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Total \_\_\_\_\_
- g. Business, corporate or partnership name: \_\_\_\_\_
- h. Name of all partners or members of the firm who provide professional services: \_\_\_\_\_  
 \_\_\_\_\_
- i. Professional societies or associations in which you are a member: \_\_\_\_\_  
 \_\_\_\_\_
- j. Please attach a copy of letterhead or other business stationery.
- k. Are you a member of the American Society of Bariatric Physicians?  Yes  No
- l. Do you presently subscribe to the ASBP Practice and Anorectic usage Guidelines?  Yes  No
- m. What percentage of your total practice was Phen-Fen drug therapy for: 1995 \_\_\_\_\_ 1996 \_\_\_\_\_ 1997 \_\_\_\_\_
- n. Corporate Medical Director and his/her medical specialty \_\_\_\_\_

**2. OPERATIONS**

- a. States Clinics are registered and licensed to practice: \_\_\_\_\_  
 \_\_\_\_\_  
 If none, please explain.
- b. Hours of Operation for each location (attach a separate sheet if necessary):

Loc	Address	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1								
2								

- c. Do you maintain any beds for overnight occupancy?  Yes  No.
- d. Total sq. ft. that you occupy (all locations): \_\_\_\_\_
- e. Division of patients or clients:
- |                               |                            |                                       |
|-------------------------------|----------------------------|---------------------------------------|
| (i) Hemodialysis _____%       | (vii) Psychiatric _____%   | (xiii) Bariatrics _____%              |
| (ii) Holistic Medicine _____% | (viii) Drug Addicts _____% | (xiv) Physical Rehabilitation _____%  |
| (iii) Surgical _____%         | (ix) Alcoholics _____%     | (xv) Disability Evaluation _____%     |
| (iv) Stress Testing _____%    | (x) Obstetrical _____%     | (xvi) Research or Experimental _____% |
| (v) Communicable _____%       | (xi) Dental _____%         | (xvii) Anti-aging Medicine _____%     |
| (vi) Family Planning _____%   | (xii) Pediatric _____%     | (xviii) Other _____%                  |
- f. Does Clinic use a collection agency? ..... [ ] Yes [ ] No  
 If yes, name of agency: \_\_\_\_\_  
 Does the agency have authority to file a collection suit on Clinics behalf? ..... [ ] Yes [ ] No
- g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?..... [ ] Yes [ ] No  
 If yes, give details including name, location, size and number of beds. \_\_\_\_\_
- h. Do you own or operate any business other than that shown in question 1a?..... [ ] Yes [ ] No  
 If yes, please attach detailed explanations of this activity.
- i. 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.
- j. Names and locations of any hospitals or institutions Clinic uses in practice: \_\_\_\_\_
- k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No  
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [ ] Yes [ ] No  
 (ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_

**3. PROFESSIONAL SERVICES**

- a. Do you perform (If yes, please provide the estimated number of procedures for the next twelve months):
- |   |                |                            |
|---|----------------|----------------------------|
| (i) Botox Injections? .....                                       | [ ] Yes [ ] No | Number of Procedures _____ |
| (ii) Chemical Peels? .....  | [ ] Yes [ ] No | Number of Procedures _____ |
| (iii) Dermal Fillers (Restylane, Collagen or other substance?) .. | [ ] Yes [ ] No | Number of Procedures _____ |
| (iv) Laser Skin Treatments? .....                                 | [ ] Yes [ ] No | Number of Procedures _____ |
| (v) Massage Therapy / Cellulite Treatments? .....                 | [ ] Yes [ ] No | Number of Procedures _____ |
| (vi) Mesotherapy or Lipodissolve? .....                           | [ ] Yes [ ] No | Number of Procedures _____ |
| (vii) Microdermabrasion? .....                                    | [ ] Yes [ ] No | Number of Procedures _____ |
| (viii) Sclerotherapy Injections? .....                            | [ ] Yes [ ] No | Number of Procedures _____ |
- b. Do you perform:
- |   |                |
|---|----------------|
| (i) Acupuncture or acupuncture anesthesia? Explain: .....                                     | [ ] Yes [ ] No |
| (ii) Chelation Therapy .....  | [ ] Yes [ ] No |
| (iii) Vitamin Injections.....   | [ ] Yes [ ] No |
| (iv) Norplant insertion/removals advise # yearly.....   | [ ] Yes [ ] No |
| (v) Surgery other than incision of superficial boils or suturing superficial fascia? .....    | [ ] Yes [ ] No |
| (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles? .....             | [ ] Yes [ ] No |
| (vii) Pain Management procedures? .....   | [ ] Yes [ ] No |
| (viii) Experimental procedures or research testing? Describe in detail on separate sheet..... | [ ] Yes [ ] No |

- c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? [ ] Yes [ ] No  
 If yes, answer (ii) and (iii) below.
- (ii) List ALL surgical procedures performed (including minor surgery): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (iii) Do you administer anesthesia (other than topical or local infiltration)? ..... [ ] Yes [ ] No  
 If yes, please attach detailed explanation.
- d. Do you use drugs for weight reduction or patients? ..... [ ] Yes [ ] No  
 If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.
- e. Do you use hCG for weight reduction or patients? ..... [ ] Yes [ ] No f.
- f. Do you administer any methadone treatment? ..... [ ] Yes [ ] No  
 If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months \_\_\_\_\_; Next 12 months \_\_\_\_\_.
- g. Number of annual x-ray exposures: for diagnosis \_\_\_\_\_; for treatment \_\_\_\_\_.
- h. If x-ray treatment is given, what qualifications are required of the staff? \_\_\_\_\_  
 \_\_\_\_\_
- i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. .... [ ] Yes [ ] No
- j. Attach detailed description of any additional activities and/or procedures which you performed.

**4. STAFF**

a. Indicate the number of professional employees, volunteers and independent contractors. If none, state NONE. If you require any of the above to be Named Insureds, submit separate application for each such individual:

	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(i) Physicians Specialty _____	_____	_____
(ii) Physicians' Assistant	_____	_____
(iii) Nurse Practitioner	_____	_____
(iv) RN / LPN	_____	_____
(v) Other: _____	_____	_____

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation? [ ] Yes [ ] No  
 If no, please attach explanation.

- c. Have any of the staff in 4.a. (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS):
- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association? ..... [ ] Yes [ ] No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... [ ] Yes [ ] No
- (iii) Ever been treated for alcoholism or drug addiction? ..... [ ] Yes [ ] No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ..... [ ] Yes [ ] No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ..... [ ] Yes [ ] No

**5. REVENUES**

a. Provide Revenue:

	<u>This Fiscal Year</u>	<u>Next Fiscal Year</u>
TOTAL GROSS REVENUE	\$ _____	\$ _____

b. Provide Number of Outpatient Visits:

<u>Type of Visit</u>	<u>Last 12 Months</u>	<u>Next 12 Months</u>
Clinic (New Patient)	_____	_____
Follow Up Visit	_____	_____
Laboratory	_____	_____
Other	_____	_____
TOTAL NO. OF VISITS	_____	_____

**6. HISTORY/CLAIMS**

a. Has any claim or suit been brought against the entity and/or any of the entity employees? ..... [ ] Yes [ ] No  
If yes, how many? \_\_\_\_\_

Complete a Supplemental Claim form for each claim (attached)

b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against the entity or any of the entity's employees? ..... [ ] Yes [ ] No

If yes, provide details on separate sheet.

c. List professional liability insurance carried for each of the past three years.

<u>Insurance Carrier</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (if any)</u>	<u>Premium</u>	<u>Inception Mo./Day/Yr.</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
							<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY 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.

WARRANTY: I/We 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/We authorize the release of claim information from any prior insurer to Carrier or Vanorsdale Insurance Services.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer to complete the insurance, but one copy of this application will be attached to the policy, if issued.