OUTPATIENT THERAPY APPLICATION

ATTACH SEPARATE SHEET WITH ANY ADDITIONAL DETAILS IF NECESSARY

Name of Entity (Including all DBAs): _____

Mailing Address: _____

Location Address(es): _____

Website address: _____

Tax Identification Number: _____ Telephone Number: (____) _____

Person to contact for survey: Name: _____Title: _____

Email Address:_____

I would also like to receive a competitive quote for the following:
☐ Property ☐ Workers' Compensation ☐ Cyber/Data Breach Liability
☐ Business Auto ☐ Employment Practices Liability ☐ Directors and Officers

Number of years entity under current ownership: _____ Number of years' experience in the field: _____

Applicant is ☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____

Is applicant licensed to do business in the states listed above where required? ☐ Yes ☐ No

Is applicant a member of any national or regional network or association? ☐ Yes ☐ No
If yes, please provide names of associations. _____

PAST 12 MONTHS
Annual Gross Revenue $ _____

Annual Payroll $ _____

Annual number of Client Contacts _____

ESTIMATED FOR NEXT 12 MONTHS
Annual Gross Revenue $ _____

Annual Payroll $ _____

Annual number of Client Contacts _____

Please provide list of all services provided._____
_____
_____
_____

How many employees/independent contractors do you employ in each of the following positions?
Physical Therapists _____ Physical Therapy Assistants _____
Occupational Therapists_____ Speech Therapists _____
Massage Therapists _____ All others, please describe _____

Do you keep daily work reports on all patients as they are seen? ☐ Yes ☐ No

Approximately what percentage of applicant's patients are under the age of 18?_____%
Approximately what percentage of applicant's practice is associated with sports injuries? _____%

Has applicant treated any professional or collegiate athletes? ☐ Yes ☐ No If yes, please answer the following questions:

How many professional athletes treated in the past 12 months? _____
How many collegiate athletes treated in the past 12 months? _____
What is the level of injury being treated? _____
What services are being provided? _____
Is each athlete required to sign a waiver prior to services being provided? ☐ Yes ☐ No

Do you offer aquatic therapy? ☐ Yes ☐ No If yes, please answer the following questions:
Is there a therapist with each patient at all times? ☐ Yes ☐ No
Do you have any type of patient lift to get in and out of the pool? ☐ Yes ☐ No
Do you ensure that the pool deck area is free of any debris to help prevent falls? ☐ Yes ☐ No
How often is the pool maintained? _____
What is the temperature of the pool? _____
How deep is the pool? _____
Is the pool ever used for anything other than therapy? ☐ Yes ☐ No If yes, please explain. _____

Do you offer dry needling or acupuncture services? ☐ Yes ☐ No
If yes, please complete supplemental application.

Do you offer any fitness classes or other type of wellness services? ☐ Yes ☐ No
If yes, please complete supplemental application.

Do you provide any spinal manipulations? ☐ Yes ☐ No
If yes, do you monitor and keep on file the certifications and education requirements required by the state to confirm that the treating therapist remains in compliance? ☐ Yes ☐ No

Are any tests conducted/results interpreted or diagnosed by the applicant? ☐ Yes ☐ No
If yes, please explain. _____

Do you sell any products? ☐ Yes ☐ No
If yes, please provide complete list of products sold.

PROFESSIONAL LIABILITY – PRIOR CARRIER INFORMATION

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

GENERAL LIABILITY – PRIOR CARRIER INFORMATION

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

3rd Prior Yr,							
4th Prior Yr.							

Has the applicant had any Professional or General Liability claims in the past five years? ☐ Yes ☐ No

Is the applicant aware of any prior incident, circumstance or occurrence that may result in a future claim?
☐ Yes ☐ No If yes, attach full details.

Has applicant had any incidents or claims reported for sexual misconduct or any other allegations of abuse?
☐ Yes ☐ No If yes, attach full details.

Has any company cancelled, declined or refused to issue similar insurance? ☐ Yes ☐ No
If yes, please explain. _____

Does applicant require all insureds, including employees and contractors, to report ALL incidents to the Named Insured no later than the end of the work day in which the incident occurred? ☐ Yes ☐ No
If no, please explain. _____
_____
_____

Check all the following that apply as part of each employee screening and hiring process:

Applications	_____	Multi-State Registry	_____
Drug / HIV / Hep. Testing	_____	Criminal Background Checks	_____
Education/Competency	_____	Licenses/Annual Confirmation	_____
Reference Verification	_____		

Are employees required to actively participate in continuing education? ☐ Yes ☐ No

Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No
Person Responsible _____ Title _____

Please provide copies of your formal written guidelines or procedures used to address the following scenarios:

- All forms of Heat Therapy or Electro Stimulation modalities of therapy including but not limited to:
  - Clients with impaired, sensitive or numb areas
  - Temperature control and maintenance of water and hot packs
  - Mentally impaired individuals or those with heat sensitivity
- Clients that are medically fragile or have challenged mobility
- Protocols or steps taken after any injury to a client

Are there written guidelines in place regarding sexual misconduct or physical abuse? ☐ Yes ☐ No

Has the applicant or any of its employees/contractors ever been subject to any of the following? If yes to any question, please attach full details.

Subject to disciplinary action or investigatory proceedings or reprimanded by any administrative or government agency, hospital or professional association? ☐ Yes ☐ No

Has any professional license been refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☐ No

Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

DATA BREACH QUESTIONS

What operating system does the applicant use? (ex. Windows 7, 8, 10, etc.) _____

How often does the applicant perform Windows updates? _____

What anti-virus software does the applicant use? _____

Does the applicant use firewall technology? ☐ Yes ☐ No

Is the anti-virus software installed on all of the applicant's/employees' business computer systems, including laptops, personal computers, and networks? ☐ Yes ☐ No

Does the applicant use intrusion detection software to detect unauthorized access to internal networks and computer systems? ☐ Yes ☐ No

Is it the applicant's policy to upgrade all security software as new releases or improvements become available? ☐ Yes ☐ No

Does the applicant provide remote access to its network? ☐ Yes ☐ No
If yes, is remote access restricted to Virtual Private Networks (VPNs)? ☐ Yes ☐ No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued, and may be attached to and become part of the policy.

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 subjects such person to criminal and civil penalties.

Must be signed by principal, partner or officer of group or individual applying for insurance.

Signature of Applicant _____

Printed Named _____

Title _____

Date _____

PLEASE PROVIDE COPIES OF THE FOLLOWING CURRENT POLICY DECLARATION PAGES SHOWING EFFECTIVE DATES, RETRO DATES AND LIMITS, SO UNDERWRITING CAN MATCH LIMITS AND APPLICABLE RETROACTIVE DATES.

Professional Liability
General Liability
Physical and Sexual Abuse
Employee Benefits Liability (if coverage needed)
Hired and Non-Owned Auto Liability (if coverage needed)