3320 W. Cheryl Drive, Suite B-122
Phoenix, AZ 85051
PHONE: 913-275-5050
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OUTPATIENT THERAPY AND REHABILITATION APPLICATION

Name of Facility: _____

Mailing Address _____

Street City State Zip

Location Address_____

Street City State Zip

1. Is applicant hospital-based or affiliated with any type of hospital or medical facility? ◯ Yes ◯ No
2. Present number of patients in each age group below:

   Under 18_____ 18 and over _____

3. **Exposure:**

   The total number of client contacts during the last three years are:_____; _____; _____.

   Annual gross receipts: _____ Last 12 months _____ Next 12 months

   Total annual payroll: _____ Last 12 months _____ Next 12 months

4. Are medication or drugs given:

   a. Only under a physician's written orders? ◯ Yes ◯ No

   b. Only by authorized medical professionals? ◯ Yes ◯ No

   If the answer to a. or b. above is no, please explain.

   _____

   _____

5. Please check ALL modalities used in treatment:

   ☐ Traditional/manual therapy
   ☐ Electric stimulation
   ☐ Strength training
   ☐ TENS
   ☐ Ultrasound

6. Is a complete physician's examination required prior to admission or treatment? ◯ Yes ◯ No
7. Is a complete medical history of each patient or client retained on premises? ◯ Yes ◯ No
8. Are medical records released to third parties without the written consent of the patient? ◯ Yes ◯ No
9. Is a comprehensive explanation of diagnosis/treatment communicated to the patient? ◯ Yes ◯ No
10. Does the application provide any fitness services? ◯ Yes ◯ No

    If Yes, what percentage of total revenue are represented by these services?_____

11. Are clients given instructions and left to perform the therapy/exercises on their own? ◯ Yes ◯ No

CLAIM HISTORY

12. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? ◯Yes ◯No

If Yes, please provide details below.

If Yes, please attach information for each claim, suit or incident that includes the following:

- ☐ Date of accident and date of notice
- ☐ Claimant name
- ☐ Amount paid or reserved
- ☐ Status – open or closed
- ☐ Insurance carrier
- ☐ Allegations
- ☐ Description of treatment rendered

SUPPLEMENTAL CLAIMS INFO

Claimant _____ Status: ◯Open ◯Closed

Date of loss _____ Date Reported _____

Expenses: Paid _____ Reserved _____

Indemnity: Paid _____ Reserved _____

Description of loss: _____

_____

Claimant _____ Status: ◯Open ◯Closed

Date of loss _____ Date Reported _____

Expenses: Paid _____ Reserved _____

Indemnity: Paid _____ Reserved _____

Description of loss: _____

_____

Claimant _____ Status: ◯Open ◯Closed

Date of loss _____ Date Reported _____

Expenses: Paid _____ Reserved _____

Indemnity: Paid _____ Reserved _____

Description of loss: _____

_____

13. Has any company cancelled, declined or refused to issue similar insurance? ◯Yes ◯No

If Yes, please provide details _____

_____

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

14. Are employees'/contractors' references contacted before hiring or placement? ◯ Yes ◯ No
Check all that apply: _____ Written _____ Verbal

15. Check all of the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:

Applications	_____	Multi-state registry	_____
Drug testing	_____	Criminal background checks	_____
Education/competency	_____	Licenses/annual confirmation	_____

16. Do you have a formal written quality assurance and risk management program? ◯ Yes ◯ No
Person responsible: _____ Title: _____

17. Does applicant participate in any health fairs/health screening/athletic events? ◯ Yes ◯ No
If Yes, what percentage of total revenue is from these services? _____

18. Does the applicant provide overnight beds or residential services? ◯ 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 containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

SIGNATURE OF APPLICANT _____ DATE _____
(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: _____Telephone Number: (____) _____

Producer's Address: _____
Street City State/Zip