

## PREGNANCY CONFIRMATION / DIAGNOSTIC SERVICES SONOGRAM APPLICATION

### General Information

Issue                       Quote

Applicant \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Date Quotation Desired? \_\_\_\_\_

Loc. No.	Location Premises (Put "Same" if same as above)	Facility Utilization (School, Office, etc)	Applicant's Interest (Own/Lease)	Sq. Ft.	# of Stories
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____

1. How long has applicant been in operation (years)? \_\_\_\_\_
2. Organized as a non-profit corporation?     Yes     No    If no, Describe: \_\_\_\_\_
3. Name of Director? \_\_\_\_\_ Medical Director? \_\_\_\_\_
4. Annual Budget \$ \_\_\_\_\_ Fiscal Year? \_\_\_\_\_
5. Describe applicant's funding \_\_\_\_\_
6. By what authority is applicant licensed? \_\_\_\_\_
7. Full description of operations \_\_\_\_\_
8. Have any claims or suits for Counseling been made against the Insured or is the Insured aware of any circumstances, which may result in any, such claim, being made against the Insured? If so, give details.  
\_\_\_\_\_
9. Attach copies of applicant's hiring standards and screening methods.
10. Does applicant assure that all personnel have mandated background inquiries?     Yes     No
11. Have any employees been subject of a child/abuse/neglect/improper supervision investigation (other than initial screening?)  
 If yes, have the investigations resulted:  
 A. Confirmed finding of abuse/neglect/improper supervision  
 B. No Finding  
 C. Other: \_\_\_\_\_
12. Is facility certified for Medicare?     Yes     No

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13. Is medication or drugs given?  Yes  No
1. Only under a physician's written orders?  Yes  No
  2. Only by authorized medical professionals?  Yes  No
  3. Are drugs administered in accordance with the rules of the Federal Drug Enforcement Agency  Yes  No

If drugs are given and the answer to 1., 2. or 3. above is NO, please explain: \_\_\_\_\_

14. Is a complete medical history of each patient or client retained on premises?  Yes  No
15. Are medical records released to third parties without the written consent of the patient or clients?  Yes  No  
 If Yes, please explain: \_\_\_\_\_

**II. PATIENT/TREATMENT INFORMATION:**

- A. Is a complete physician's examination done, to include sonogram?  Yes  No
- B. Does the facility afford off-premises services?  Yes  No  
 If Yes, please describe the services rendered in detail and location(s): \_\_\_\_\_
- C. Any limit on the number of patients clinic is licensed to serve?  Yes  No
- D. If the facility engaged in vocational training activities/services?  Yes  No  
 If Yes, please describe the vocational training activities in detail: \_\_\_\_\_

**III. SERVICES PROVIDED**

Clients served - the number of client serviced by the facility should be entered below, where appropriate:

Please indicate number of **Clients per Day** \_\_\_\_\_ Pregnancy Sonogram Confirmations \_\_\_\_\_  
 Pregnancy Counseling \_\_\_\_\_ Other, specify \_\_\_\_\_  
 Workshops \_\_\_\_\_

Please indicate the number of **Annual Outpatient or Client Site Visits**.  
 Pregnancy Related Counseling \_\_\_\_\_ Other, specify \_\_\_\_\_

Please indicate number of **Calls**.  
 Hotline \_\_\_\_\_ Information \_\_\_\_\_  
 Referral \_\_\_\_\_ Other, specify \_\_\_\_\_

**IV. SCHEDULE OF NONPHYSICIAN STAFF:**

	<b>Number of</b>	
	<b>Full Time</b>	<b>Part Time</b>
Administrators	_____	_____
Clerical	_____	_____
Counselors	_____	_____
Homemakers/Aides	_____	_____
Nurses	_____	_____
Psychologists	_____	_____
Social Workers	_____	_____
Students	_____	_____
Volunteers	_____	_____
Others, specify	_____	_____

SCHEDULE OF PHYSICIAN STAFF

<u>Name</u> <u>Insurance?</u>	<u>Specialty</u>	<u>Board</u> <u>Certified</u>	<u>Board</u> <u>Eligible</u>	<u>Hours</u> <u>Worked</u>	<u>Volunteer,</u> <u>Contracted</u> <u>Per Week</u>	<u>Carries Own</u> <u>Malpractice</u> <u>or Employed</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**V. Physician Credential (Use a separate sheet if necessary?)**

1. What limit of Medical Malpractice Insurance is carried by the Physician(s) above?
2. Please attach Certificates of Medical Malpractice Insurance, which includes your entity as an additional insured for each physician.
3. Have you thoroughly reviewed all past and present hospital affiliations?
4. Have any hospital affiliations resulted in any voluntary or involuntary termination of medical staff membership?
5. Any voluntary or involuntary reduction, limitation or loss of clinical privileges at any other hospital?
6. Any involvement in past and pending malpractice and professional misconduct claims?
7. Any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration or the voluntary relinquishment of any such licensure or registration)?
8. Has medical school completion been verified in order to rule out falsification of credentials?
9. Do any of the physicians have a history of treatment for drug, alcohol or substance dependency?
10. Have licensure and references been verified in writing?

Supplemental Information

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Refer to Item Number: \_\_\_\_\_

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## Patriot Insurance Agency, Inc.

PO Box 1298  
Sonoita, AZ 85637-1298  
(520) 455-9252  
(520) 455-9358 Fax  
(800) 859-2724 Toll Free  
Email:

[PatriotInsAgency@aol.com](mailto:PatriotInsAgency@aol.com)

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Dear Director:

This application duly completed together with any supplementary information must be signed. Signature of the Application does not bind the insurance company or the underwriters to the insurance. Applicant's signature acknowledges the understanding that this pregnancy diagnostic insurance coverage is Professional Liability limited to covering claims resulting from the use of sonogram confirmation services and does not include medical services such as blood work, pap smears, laminary removal, social disease testing, prenatal care or covers in any way the physician(s) who may be assisting with these services. Medical exposures are subject to full medical malpractice insurance and require a separate application. This insurance program will cover those who use the sonogram equipment, the technicians, nurses, and all those other than the physicians who may operate the equipment to provide pregnancy confirmation and diagnostic services.

**FRAUD STATEMENT:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicants Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Position \_\_\_\_\_

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**CHECKLIST FOR CLINICAL SERVICES**

Customer Number: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Services Provided:**

SONOGRAM:

Vaginal Probe:

External Probe:

Doppler

TESTING FOR SEXUAL TRANSMITTED DISEASES

BLOOD WORK

LAMINARY REMOVAL

ANY PRE NATAL CARE

\*\*\*IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES\*\*\*

**GYNECOLOGIST SERVICES**

\*\*\*IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES\*\*\*

OTHER SERVICES:

\*\*\*IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES\*\*\*

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**DOCTOR(S) TO BE INCLUDED**

If Yes, please provide a copy of the Doctor/Physician's license and also a Description of the type of services they will be providing.

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Director's Signature

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Date