

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:

	Number of	
	Full Time	Part Time
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

Refer to Item Number: _____



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

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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 _____

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

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.

Director's Signature

Date