



american naturopathic member application



Identifying Information *(Please complete entire application. Print neatly in black ink or type answers.)*

Full Name		Practice Name (if applicable)		Phone
Office Address		City	State	Zip
Mailing Address <i>(If Different from Above)</i>		City	State	Zip
Email Address		Social Security Number		Birthdate
Naturopathic License #	State Issued	Issue Date	License Current?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Naturopathic School Attended
				Date Completed

Professional Information *(If you answer YES to any of questions 1 through 11, attach an explanation)*

- Has any suit, arbitration, or other claim or proceeding been brought against you, your professional practice, associates, or employees for alleged malpractice? Yes No
- Do you know of any circumstances since your last application that would give rise to a claim being brought against you, your professional practice, associates or employees for professional malpractice? Yes No
- Has any agency investigated, suspended, revoked, or taken any action against your license to practice? Yes No
- Have you used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties; or used any illegal drug in the past year? Yes No
- Have you been convicted of violating any law or ordinance other than a minor traffic offense? Yes No
- Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association? Yes No
- Do you treat cancer or epilepsy? Yes No
- Do you ever use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness Device? Yes No
- Do you ever charge or collect fees before the day care is given, i.e. prepaid per case, on a contract, etc? Yes No
- Do you ever use a collection agency with patients? Yes No *If Yes, is are they authorized to sue to collect?* Yes No
- Have you (or an agency on your behalf) filed suit to collect sums due from patients? Yes No
- Have you used a practice management company? Yes No *If Yes, provide name:*
- Standard Modalities - Check each of the following treatment modalities you have used, or intend to use in your practice:

<input type="checkbox"/> Acupuncture ^a	<input type="checkbox"/> Diathermy	<input type="checkbox"/> Nutritional Therapy	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Behavioral ^b	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Paracentesis	<input type="checkbox"/> Weight Control ^c
<input type="checkbox"/> Bio Feedback	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Physical Therapy	
<input type="checkbox"/> Botanical / Herbal Medicine	<input type="checkbox"/> Manipulation Therapy ^a	<input type="checkbox"/> Thoracentesis	

a – A separate application addendum is required if you desire coverage to extend to either acupuncture or manipulation under anesthesia. Please request. b – Includes Counseling, Psychological Care, Stress Mgmt, etc. c - Other than diet and exercise

- Class II or Class III Modalities: Check any or all treatment modalities you have used, or intend to use in your practice:

<input type="checkbox"/> Cheleation Therapy (II or III)	<input type="checkbox"/> Hypnosis (III)	<input type="checkbox"/> Obstetrics / Deliveries (III)	<input type="checkbox"/> Prolo / Sclero Therapy (III)
<input type="checkbox"/> Colonoscopy (II)	<input type="checkbox"/> Needle Biopsies (II)	<input type="checkbox"/> Office surgery (II or III)	<input type="checkbox"/> Experimental/Other Therapy (II or III)
<input type="checkbox"/> Gynecology (II or III)	<input type="checkbox"/> Neonatal/Prenatal Care (II or III)	<input type="checkbox"/> Prescription Drugs (II or III)	

A separate application addendum must be completed and approved in order for coverage to extend to any Class II or Class III modalities. If applicable, please request an addendum promptly.

15. Do you use any technique or therapy that is not currently taught in the naturopathic schools and colleges? Yes No

If Yes, please list: _____

16. Do you accept Medi-Cal / Medicaid? Yes No If Yes, what % of your practice is Medi-Cal / Medicaid? _____ %

17. Do you make a differential diagnosis? Yes No If No, do you limit your responsibility to treating symptoms? Yes No

18. Do you perform cervical adjustments? Yes No If Yes, do you regularly use the Georges Test, the Vertebral Artery Ischemia Test, or the Cerebrovascular Cranio Cervical Function Test? (If NO, please explain) Yes No

19. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (If Yes, explain) Yes No

20. If the quality of an x-ray is marginal, do you always do (or order) a retake? Yes No

21. Do you refer to other providers? Yes No If Yes, circle: MD ND DO DPM DC L.Ac. RN RPT Other: _____

22. Do you always record the patient's account of his or her progress? Yes No No, but I will do so now.

23. Do you always record objective findings? Yes No No, but I will do so now.

24. Do you always record details of treatment procedures? Yes No No, but I will do so now.

25. Are you licensed to practice any other health care professions? Yes No

If Yes, please circle: MD, DO, DPM, DC, RN, RPT, Other _____

If Yes, name malpractice carrier for other profession: _____ Policy expires: _____

26. Which best describes your practice structure: Sole Proprietor Contractor Professional Corp Partnership Employee

List names of Entity, Partners, and / or Employers: _____


27. Do you wish coverage for your corporation, partnership or any other entity or person? (An additional charge applies) Yes No

If Yes, please print name(s): _____

28. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (attach additional sheets if necessary):

29. Number of patients you see weekly: _____ Number of hours per week in direct professional work with patients: _____

30. On what date would you like your coverage to be effective? (May not be before the date this application is received) _____

 **Signatures** (Signatures are required in **three** places.)

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my professional

liability policy. I understand that untrue statements could void my insurance policy.

Sign: _____ Date: _____

CLAIMS-MADE ONLY: I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no

coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the insured purchased an Extended Coverage Policy within 30 days after termination.

Sign: _____ Date: _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed, and that any price distinctions based on safe naturopathic practices may be based in part on information provided by me on future follow-up data sheets or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have

the duty to report in writing, within 48 hours or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

Sign: _____ Date: _____

 **Mail App and Payment:**

Scott Danahy Naylor
300 Spindrift Dr.
Buffalo, NY 14221
800.728.6362 · 716.633.7141 Fax

 **To Pay by Credit Card, Complete the Following:**

Card # _____ Expires _____
You are authorized to charge the above card for the amount indicated on my invoice for coverage through American Naturopathic Council. I agree to pay this amount according to the terms of the card issuer agreement.
Signature of Cardholder: _____