HEALTHCARE*Pros*
Insurance Solutions for Healthcare Service Providers

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AMBULATORY SURGICAL CENTERS

PROFESSIONAL AND GENERAL LIABILITY INSURANCE
CLAIMS MADE AND REPORTED BASIS

PLEASE TYPE OR PRINT IN INK

Effective date desired:_____

I. GENERAL INFORMATION:

1. Complete name of facility (applicant) (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary):** _____

   _____

   Address: _____

   City: _____ State: _____ Zip:_____ County: _____

   Contact name: _____ Title:_____ Email address: _____

   Phone: _____ Web site Address: _____ Fax: _____

   List all other locations **(use an additional sheet of paper if necessary):** _____

   _____

   _____

   Is the facility licensed in each state? _____ ❑ Yes ❑ No

2. Applicant is: a. ❑ Partnership ❑ Corporation ❑ Professional Association ❑ Other: _____

   b. ❑ Not-for-profit ❑ For-profit ❑ Both

3. Date established: ____/ ____

4. Current accreditations or associations: ❑ AAAHC ❑ AAAASF ❑ JCAHO ❑ Other: _____

5. Is the applicant engaged in, owned by or associated with or controlled by any other business? ❑ Yes ❑ No
   If yes, give details (use an additional sheet of paper if necessary): _____

6. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$_____	$_____
Medicare/Medicaid Funds	$_____	$_____
Research	$_____	$_____
Other (describe)	$_____	$_____
TOTAL GROSS REVENUES:	$_____	$_____

II. OPERATIONS:

1. a. Applicant's hours of operation: _____
   b. Do you maintain any beds for overnight occupancy? ❑ Yes ❑ No

      If yes, please explain. _____
   c. Indicate three (3) largest (patient volume) departments by specialty.

      (i) _____ approximate percentage to total volume _____ %

(ii) _____ approximate percentage to total volume _____%
(iii) _____ approximate percentage to total volume _____%

d. Annual number of Minor Surgical Procedures performed: _____
Annual number of Major Surgical Procedures performed: _____

e. Do you have the following equipment at the center? ❑ Yes ❑ No
Laboratory, with the following capabilities -- CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine? ❑ Yes ❑ No
X-ray with on-premises processing? ❑ Yes ❑ No
EKG -- 12 lead? ❑ Yes ❑ No
Monitor/Defibrillator? ❑ Yes ❑ No
Crash cart with full cardiac life support capabilities and necessary intravenous fluids? ❑ Yes ❑ No
Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage? ❑ Yes ❑ No
Oxygen? ❑ Yes ❑ No
Suction? ❑ Yes ❑ No
Pneumatic anti-shock trousers? ❑ Yes ❑ No

f. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ❑ Yes ❑ No
If Yes,
Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ❑ Yes ❑ No
(HIPAA) Privacy Rule?
Provide the name and title of the Applicant's Privacy Officer. _____

III. PROCEDURES:

a. Do you maintain adequate medical records for each patient? ..... ❑ Yes ❑ No
(i) How often and by whom are the medical records reviewed? _____
_____
(ii) What arrangements are made for transmitting medical records to other requesting physicians?
_____

b. Does the Applicant have
(i) A formal emergency response policy which includes written transfer agreements with the receiving acute care hospital(s)? ❑ Yes ❑ No
(ii) A dedicated telephone line to the closest appropriate hospital Emergency Department? ❑ Yes ❑ No
(iii) Two-way communication with EMS? ❑ Yes ❑ No
(iv) Is the Applicant staffed with professional personnel trained in emergency response during all hours of operation? . ❑ Yes ❑ No

If any of the above is answered No, explain. _____

c. What is the distance from the Applicant to the nearest acute care hospital Emergency Department? _____

4. Does the Applicant have a:
(a) Formal laser safety and surgical fire prevention program? ❑ Yes ❑ No
(b) Preventive maintenance program for all anesthesia and critical emergency equipment? ❑ Yes ❑ No
(c) Formal process to minimize the risk of wrong patient/procedure/side/site surgery that includes validation by the patient/legal representative and documentation of the steps taken by all members of the surgical team to accurately identify the correct procedure, side and site including re-verification in the operating room prior to surgery? ❑ Yes ❑ No
(d) Formal process to verify and document that ambulatory surgery patients have an appropriate screening by a physician to exclude high risk patients or procedures, (e.g., by ASA criteria or other formal guidelines)? ❑ Yes ❑ No

If the answer to (b), (c) or (d) above is No, explain. _____

5. Does the Applicant have a formal policy which requires documentation of all pre-operative care that includes

the following: .....

(a) Pre-operative history and physical exam? ❑ Yes ❑ No
(b) Pre-operative laboratory and ECG review by a surgeon and anesthesia provider? ❑ Yes ❑ No

(c) Pre-operative nursing assessments? ❑ Yes ❑ No
(d) Pre-operative anesthesia evaluation and airway assessment per ASA guidelines ❑ Yes ❑ No
(e) Documentation of informed consent for surgery and anesthesia prior to administration of pre-operative medication? ❑ Yes ❑ No

If the answer to any of the above questions is No, explain. .....

6. Does the Applicant have a formal policy which requires documentation of all intra and post-operative care that includes the following:

(a) Patient identification, procedure, site, side re-verification? ..... ❑ Yes ❑ No
(b) Positioning, electrical and laser safety precautions? ..... ❑ Yes ❑ No
(c) Anesthesia assessment and continuous physiologic monitoring? ..... ❑ Yes ❑ No
(d) Documentation and signing of all intra-operative orders? ..... ❑ Yes ❑ No
(e) All medications and intravenous fluids? ❑ Yes ❑ No
(f) Disposition of all specimens sent to pathology? ..... ❑ Yes ❑ No
(g) Validation of sponge, needle and instrument counts, actions taken if count is not correct? ..... ❑ Yes ❑ No
(h) Condition, mode of transport and clinical status of patient, transfer report upon completion of procedure and transfer to post-anesthesia care area? ..... ❑ Yes ❑ No
(i) Signing of all postoperative order and timely dictation of operative notes? ..... ❑ Yes ❑ No

If the answer to any of the above questions is No, explain. _____

7. Does the Applicant have a formal discharge policy which requires that patients

(a) Meet specific clinical discharge criteria? ..... ❑ Yes ❑ No
(b) Be examined by a licensed provider and anesthesia provider prior to discharge? ..... ❑ Yes ❑ No
(c) Receive written and individualized discharge instructions detailing emergency care procedures with signatures of the patient and discharge provider with copies retained by the Applicant? ..... ❑ Yes ❑ No
(d) Are prevented from driving themselves home or taking public transportation post procedure? ..... ❑ Yes ❑ No
(e) Receive a documented status call-back phone call from the Applicant center within 24 hours of discharge? [ ] Yes [ ] No

If any of the above questions are answered No, explain: .....

8. Does the Applicant offer professional advise to the public via the internet, newspapers or broadcasts? .. ❑ Yes ❑ No

If Yes, explain._____

a. Does the applicant provide medical services for other than fee for service? ❑ Yes ❑ No
If yes, give details or arrangements, including copy of contract(s).
What is patient mix? Fee for service: _____ % Prepaid: _____ %
Percent of prepaid patients referred to outside physicians: _____%

b. Do you administer any methadone treatment? ❑ Yes ❑ No
If yes, please attach description of treatment and controls used and indicate the number of treatments during:
Last 12 months _____ Next 12 months _____

IV. INTERNAL PROCEDURES

1. Is anesthesia used? ❑ Yes ❑ No
If yes, answer the following questions:
a. Type of anesthesia used? _____

b. Who administers anesthesia? _____

c. What monitoring equipment is used for anesthesia administration? _____

d. Does the Applicant permit professionals *other than* licensed Nurse Anesthetists and Anesthesiologists to administer and/or monitor sedation or general anesthesia? ..... ❑ Yes ❑ No

If Yes, do RN's administer Propofol sedation for any procedures? ..... ❑ Yes ❑ No

If Yes,

Do all such RN's have current certification in ACLS? ..... ❑ Yes ❑ No

Attach patient selection guidelines and protocols for administration and monitoring. ❑ Yes ❑ No

2.. Are signed patient consent forms required for the following:
- a. Admission? ❑ Yes ❑ No ❑ N/A
- b. Surgery? ❑ Yes ❑ No ❑ N/A
- c. Against medical advice? ❑ Yes ❑ No ❑ N/A
- d. Any other medical treatment or dispensing of drugs? ❑ Yes ❑ No ❑ N/A

3.. Do records reflect that the patient was advised of surgical procedures and possible risks associated with such procedures (informed consent)? ❑ Yes ❑ No ❑ N/A

4.. Are written post-operative orders submitted and signed by the surgeon? ❑ Yes ❑ No ❑ N/A

5.. Are sponge, needle and instrument counts performed before and after surgery? ❑ Yes ❑ No ❑ N/A

6.. Are nursing charts maintained, including patient's condition at discharge? ❑ Yes ❑ No ❑ N/A

7. How long are patients kept after the surgery/procedure? _____

8. Who monitors patients during recovery? _____

9. Are patients ever kept overnight? ❑ Yes ❑ No

V. STAFF PRIVILEGES:

Are credentials for new staff members checked and approved prior to granting staff privileges? ❑ Yes ❑ No ❑ N/A
By whom? _____

Staff member's Medical Professional Liability Insurance:

a. Are all medical staff members/independent contractors required to maintain Medical Professional Liability Insurance? ❑ Yes ❑ No

b. What limits are required? _____

c. What evidence of compliance is required?

VI. SERVICES:

1. Indicate the number of procedures provided by year.

Type of Procedure	Number of Procedures		
	Last Year	Current Year	Estimate Next Year
Bariatric Surgery	_____	_____	_____
Cosmetic Surgery	_____	_____	_____
Dental/Oral Surgery	----------	----------	----------
Elective Abortions			
1st Trimester	_____	_____	_____
2nd Trimester	_____	_____	_____
Endoscopy/Colonoscopy	_____	_____	_____
General Surgery	_____	_____	_____
Gynecological Surgery	_____	_____	_____
Manipulation Under Anesthesia	_____	_____	_____

Ophthalmology	_____	_____	_____
Orthopedic Surgery	_____	_____	_____
Otorhinolaryngology with Plastic	_____	_____	_____
Otorhionolaryngology No Plastic	_____	_____	_____
Pain Management (other than Anesthesia or other specialties)	_____	_____	_____
Plastic/Reconstructive Surgery	_____	_____	_____
Podiatry	_____	_____	_____
Radiological/Nuclear/ Chemotherapy	_____	_____	_____
Other (describe)_____	_____	_____	_____
TOTAL EACH YEAR	_____	_____	_____

2. Are any cosmetic procedures performed? ❑ Yes ❑ No
   If yes,

   Is any person other than a licensed and credentialed physician/surgeon allowed to administer

   Botox or any other cosmetic injectable, including fillers? ❑ Yes ❑ No
   If Yes, attached details and criteria for credentialing and supervision.

   Is liposuction performed? ❑ Yes ❑ No

   If Yes, volume of fluid injected and removed:

   (i) before surgery _____cc's

   (ii) after surgery _____cc's

3. Are any cosmetic procedures other than those described in (b) and (c) performed?

   If Yes, describe: _____

4. Are any surgical procedures performed for the purpose of weight reduction? ❑ Yes ❑ No
   If Yes,

   (i) If the Applicant provides any of the following procedures, check all that apply and provide the number of procedures performed:

   Roux-en-Y:

   ____ Laparoscopic:

   No. performed in past 12 months: _____

   No. expected to perform in next 12 months: _____

   ____ Open:

   No. performed in past 12 months: _____

   No. expected to perform in next 12 months: _____

   Banding:

   ____ Laparoscopic:

   No. performed in past 12 months: _____

   No. expected to perform in next 12 months: _____

   ____ Open:

   No. performed in past 12 months: _____

   No. expected to perform in next 12 months: _____

(II) Gastric Restriction, Other (describe): _____

No. performed in past 12 months: _____

No. expected to perform in next 12 months: _____

Attach protocols for selecting and monitoring patients for each type of procedure performed.

VII. STAFF:

a. Do you have any restricted licensed physicians on staff? ❑ Yes ❑ No
If yes, please explain. _____
_____

b. Do you have any physicians on staff that do not maintain staff privileges at a hospital? ❑ Yes ❑ No
If yes, please explain. _____
_____

c. Please describe peer review process for surgeons. _____

d. Does the applicant require Certificates of Insurance from all staff doctors? ❑ Yes ❑ No
If yes, what are minimum limits of liability that are required? _____ (per claim) _____ (aggregate)

c. Please indicate the number of professional employees, including any owners or partners who render professional services on behalf of the applicant whether or not surgical.

IF NONE, PLEASE STATE NONE.

		No of Employees	**No. of Independent Contractors**
(i)	Physicians: No surgery other than incision of boils and superficial abscesses; suturing of skin or superficial facia	(i) _____	_____
(ii)	Physicians: Minor surgery or obstetrical procedures not constituting major surgery:	(ii) _____	_____
(iii)	Bariatric Surgeons (iii)		
(iv)	Dermatologist; Internists; Proctologists, Ophthalmologists and Urologists:	(iii) _____	_____
(v)	General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery):	(iv) _____	_____
(vi)	Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery:	(v) _____	_____
(vii)	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons:	(vi) _____	_____
(viii)	Podiatrist: (viii)		
(ix)	Physicians' & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet):	(vii) _____	_____
(xi)	Moonlighting Residents		
(xii)	Interns/residents in a formal program in applicant's facility	(viii) _____	_____
(xiii)	Unlicensed Interns:	(ix) _____	_____
(xiv)	Dentists (no oral surgery):	(x) _____	_____
(xv)	Orthodontists:	(xi) _____	_____
(xvi)	Oral Surgeons:	(xii) _____	_____
(xvii)	Nurse Anesthetists:	(xiii) _____	_____
(xviii)	Optometrists, Opticians:	(xiv) _____	_____
(xix)	Pharmacists:	(xv) _____	_____
(xx)	Perfusionists:	(xvi) _____	_____
(xxi)	Podiatrists:	(xvii) _____	_____

	No of Employees	No. of Independent Contractors
(xxii) Chiropractors:	(xviii) _____	_____
(xxiii) RNs, LPNs:	(xix) _____	_____
(xxiv) X-ray Technician; Lab Technician:	(xx) _____	_____
(xxv) Physical, Respiratory and Inhalation Therapists:	(xxi) _____	_____
(xxvi) Other miscellaneous medical personnel; (please specify and attach a list):	(xxii) _____	_____

h. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No
If no, please attach explanation.

VIII. INSURANCE:

Do you currently carry the following:

a. **Professional Liability Insurance?** ❑ Yes ❑ No
List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period From: MM/DD/YY	To: MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

b. **Commercial General Liability Insurance?** ❑ Yes ❑ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

VIII. CLAIMS HISTORY:

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS OR COMPLETE THE ATTACHED CLAIM SUPPLEMENT FOR EACH CLAIM

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑ Yes ❑ No
If yes, provide full details. _____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No
If yes, fully describe the circumstances and follow up action taken:_____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most states:
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature Title Date

PLEASE FURNISH THE FOLLOWING ADDITIONAL INFORMATION:

a. A copy of your letterhead/business stationery.
b. List of activities/procedures performed, not otherwise described in this application.