

AMBULATORY SURGICAL CENTERS PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Desired effective date: _____

GENERAL INFORMATION

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

Address: _____

City: _____ State: _____ County: _____ ZIP: _____

Contact Name: _____ Title: _____

Contact Email Address: _____ Phone: _____

Website URL: _____

List all other locations: _____

2. Is the facility licensed in each state? Yes No

3. Applicant is:

a. Individual Partnership Corporation Professional Association Other: _____

b. Not-for-Profit For-Profit Both

4. Date established: _____

5. Current accreditations or associations: AAAHC AAAASF JCAHO Other:

6. Is the applicant engaged in, owned by or associated with or controlled by any other business? Yes No

If yes, provide details (use an additional sheet of paper if necessary):

7. Applicant's gross revenues:

	Past 12 Months	Next 12 Months
Fee for Service	\$ _____	\$ _____
Medicare/Medicaid Funds	\$ _____	\$ _____
Research	\$ _____	\$ _____
Other (describe):	\$ _____	\$ _____
TOTAL GROSS REVENUES	\$ _____	\$ _____

OPERATIONS

1. Applicant's hours of operation: _____

2. Do you maintain any beds for overnight occupancy? Yes No

If yes, explain: _____

3. Indicate three (3) largest (by patient volume) departments by specialty.

a. Specialty: _____ Approximate percentage to total volume: _____ %

b. Specialty: _____ Approximate percentage to total volume: _____ %

c. Specialty: _____ Approximate percentage to total volume: _____ %

4. a. Annual number of **minor** surgical procedures performed: _____
- b. Annual number of **major** surgical procedures performed: _____
5. Do you have the following equipment at the center?
 - a. Laboratory with the following capabilities: CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine?
 Yes No
 - b. X-ray with on-premises processing? Yes No
 - c. EKG—12 lead? Yes No
 - d. Monitor/defibrillator? Yes No
 - e. Crash cart with full cardiac life support capabilities and necessary intravenous fluids? Yes No
 - f. Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage? Yes No
 - g. Oxygen? Yes No
 - h. Suction? Yes No
 - i. Pneumatic anti-shock trousers? Yes No
6. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
If yes,
 - a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 - b. Name and title of the applicant's privacy officer: _____

PROCEDURES

1. Do you maintain adequate medical records for each patient? Yes No
 - a. How often and by whom are the medical records reviewed?
 - b. What arrangements are made for transmitting medical records to other requesting physicians?
2. Does the applicant have any of the following?
 - a. A formal emergency response policy which includes written transfer agreements with the receiving acute care hospital(s)? Yes No
 - b. A dedicated telephone line to the closest appropriate hospital Emergency Department? Yes No
 - c. Two-way communication with EMS? Yes No
 - d. Is the applicant staffed with professional personnel trained in emergency response during all hours of operation? Yes No

If no to any of the above, explain:
3. 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, (such as by ASA criteria or other formal guidelines)? Yes No

If no to b, c, or d above, explain:



5. Does the applicant have a formal policy which requires documentation of all pre-operative care that includes any of 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 no to any of the above, 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 no to any of the above, 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 no to any of the above, 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, provide 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: _____



INTERNAL PROCEDURES

1. Is anesthesia used? Yes No

If yes, answer the following questions:

- a. What type of anesthesia is 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.

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

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?: _____





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 Abortion – First Trimester			
Elective Abortion – Second Trimester			
Endoscopy/Colonoscopy			
General Surgery			
Gynecological Surgery			
Manipulation Under Anesthesia			
Ophthalmology			
Orthopedic Surgery			
Otorhinolaryngology with Plastic			
Otorhinolaryngology 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,

a. 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.

b. Is liposuction performed? Yes No

If yes, volume of fluid injected and removed:

i. Before surgery: _____ CCs

ii. After surgery: _____ CCs

3. Are any cosmetic procedures performed other than those described above?

If yes, explain:



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

If yes, complete the following.

a. If the applicant provides any of the following procedures, check all that apply and provide the number of procedures performed:

Roux-en-Y:

Laparoscopic:

Number performed in past 12 months: _____

Number expected to perform in next 12 months: _____

Open:

Number performed in past 12 months: _____

Number expected to perform in next 12 months: _____

Banding:

Laparoscopic:

Number performed in past 12 months: _____

Number expected to perform in next 12 months: _____

Open:

Number performed in past 12 months: _____

Number expected to perform in next 12 months: _____

Gastric Restriction, other (describe): _____

Number performed in past 12 months: _____

Number expected to perform in next 12 months: _____

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

STAFF

1. Do you have any restricted licensed physicians on staff? Yes No

If yes, explain:

2. Do you have any physicians on staff that do not maintain staff privileges at a hospital? Yes No

If yes, explain:

3. Please describe peer review process for surgeons:

4. 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: \$ _____



5. 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 enter "none."

	Employee	Number of Employees	Number of Independent Contractors
i.	Physicians: No surgery other than incision of boils and superficial abscesses; suturing of skin or superficial facia	_____	_____
ii.	Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____
iii.	Bariatric Surgeons	_____	_____
iv.	Dermatologists; Internists; Proctologists, Ophthalmologists and Urologists	_____	_____
v.	General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____
vi.	Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____
vii.	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____
viii.	Podiatristw	_____	_____
ix.	Physicians' and Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet)	_____	_____
x.	Moonlighting Residents	_____	_____
xi.	Interns/residents in a formal program in applicant's facility	_____	_____
xii.	Unlicensed Interns	_____	_____
xiii.	Dentists (no oral surgery)	_____	_____
xiv.	Orthodontists	_____	_____
xv.	Oral Surgeons	_____	_____
xvi.	Nurse Anesthetists	_____	_____
xvii.	Optometrists, Opticians	_____	_____
xviii.	Pharmacists	_____	_____
xix.	Perfusionists	_____	_____
xx.	Podiatrists	_____	_____
xxi.	Chiropractors	_____	_____
xxii.	RNs, LPNs	_____	_____
xxiii.	X-ray Technicianw, Lab Technicianw	_____	_____
xxiv.	Physical, Respiratory and Inhalation Therapists	_____	_____
xxv.	Other miscellaneous medical personnel (specify on an attached list)	_____	_____

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





EXISTING INSURANCE

Do you currently carry the following:

- 1. Professional Liability Insurance? Yes No

If yes, 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	Policy Period 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? _____

- 2. 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? _____

CLAIMS HISTORY

- 1. 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.

IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

- 2. 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:

- 3. 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:





APPLICANT SIGNATURE PANEL

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, 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.

Authorized signature

Date

Typed or printed name:

Title:

PLEASE FURNISH THE FOLLOWING ADDITIONAL INFORMATION:

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