U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

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.