GREENHILL
INSURANCE SERVICES

Mailing Address:
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Houston, Texas 77056
WWW.GRNHLL.COM

Mental Health Practitioner's Application (Individual Coverage)

1. Name and address of applicant: _____

_____

Telephone number: _____ Good time to call: _____

Email Address: _____ Tax ID: _____

2. Applicant is licensed as: _____ License number: _____

Of what professional associations or societies is applicant a member in good standing? _____

_____

3. Indicate highest degree held by applicant: ☐ Bachelor ☐ Master ☐ Doctorate ☐ Other

Describe: _____

4. Do you provide your services under a trade name? ☐ Yes ☐ No Name: _____

If **YES**, do other professionals practice under the same trade name? ☐ Yes ☐ No

If **YES**, please explain: _____

_____

5. Applicant practices as: Annual Income Last Year: $_____

Estimated Income Next 12 Months: $_____

a) Student: ☐ Fulltime ☐ Part-time. If also working professionally: ☐ Intern ☐ Other

b) Full time employee of _____

c) Part time employee of _____

d) Contract employee or consultant to _____

e) Private practice (self-employed) working approximately _____ # hrs. per year.

[Complete all applicable sections (a) to (e)]

6. Estimated number of client/patient contacts (including persons tested/evaluated whether or not seen by applicant) next 12 months. _____

7. Do you supervise the professional services of any other mental health practitioners? ☐ Yes ☐ No

If **YES**, please indicate how many supervised? _____ Fully describe your supervisory responsibilities.

_____

8. Does applicant sell, rent, or otherwise distribute any products (including but not limited to: records, audio tapes, video tapes, films, etc.) ☐ Yes ☐ No

If **YES**, please describe products: _____

_____

Also, do you carry comprehensive general liability insurance including products coverage? ☐ Yes ☐ No

9. Describe any physical contact (other than handshakes, pats on the back, etc.) which may occur between you and any patients/clients or between two or more patients/clients at your direction: _____

_____

10. **ENCLOSE A COPY OF YOUR LETTERHEAD, ALONG WITH ANY BROCHURES OR ADVERTISING MATERIALS DISTRIBUTED BY YOU.**

11. Does applicant utilize any of the following modalities? IF YES, give % of practice.

Hypno Therapy	☐ Yes ☐ No	If yes, _____ %
Biofeedback	☐ Yes ☐ No	If yes, _____ %
Kinesthetics	☐ Yes ☐ No	If yes, _____ %
Psychodrama	☐ Yes ☐ No	If yes, _____ %
Bioenergetics	☐ Yes ☐ No	If yes, _____ %

12. Does applicant's practice involve the following? If **YES**, give % of practice, by income, hours or number of patients.

Child/pediatric therapy	☐ Yes ☐ No	If yes, _____ %
Criminal offender therapy/evaluation	☐ Yes ☐ No	If yes, _____ %
Therapy for victims of criminal sexual abuse	☐ Yes ☐ No	If yes, _____ %
Therapy for substance abusers	☐ Yes ☐ No	If yes, _____ %
Crisis Intervention	☐ Yes ☐ No	If yes, _____ %
Therapy for sexual response/disfunction	☐ Yes ☐ No	If yes, _____ %
Diagnosis or treatment of "failed/repressed" memory syndrome	☐ Yes ☐ No	If yes, _____ %

13. List prior Professional Liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date? _____

14. COMPLETE ATTACHED EXCEPTION SUPPLEMENT.

I am licensed or duly authorized in all states or jurisdictions where I provide professional services, and I DO HEREBY WARRANT the truth of my answers to the above questions, and that I have not withheld any information which is calculated to influence the judgment of the Insurance Company in considering this application for insurance.

Date _____ Signature of Applicant _____

WARNING: Filing an application for insurance which contains false information or which conceals information for the purpose of misleading the company may result in coverage being denied, voided or rescinded with respect to any policy of insurance issued in reliance upon said application.

FOR COMPANY USE ONLY

MEM. VER.	RENEWAL	NEW	EFF. DATE	OTHER

MENTAL HEALTH PRACTITIONERS - EXCEPTIONS SUPPLEMENT

15. UNLESS OTHERWISE NOTED HEREUNDER, THE FOLLOWING ARE TRUE STATEMENTS. EXPLAIN EXCEPTIONS BELOW. GIVE # TIMES ANNUALLY IF (A), (B), (C) OR (D) APPLICABLE.

a) Applicant does not conduct group therapy sessions which exceed four (4) hours in duration;

b) Applicant does not conduct any seminars workshops or other "group activities" away from his/her regular office premises which involve more than 25 patients/clients in any one occasion;

c) Applicant does not routinely provide testimony i) in child custody hearings, ii) in competency hearings, iii) as an expert witness in legal proceedings. IF YES, how many times last 3 yrs?

d) Applicant does not assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying or apprehending criminal offenders;

e) Not more than twenty-five percent (25%) of applicant's patients/clients are referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client;

f) Applicant has no employees (W-2) registered, licensed or authorized to practice any profession;

g) Applicant has no contract employees (1099) registered, licensed or authorized to practice any profession;

h) Applicant is not a principal with any other healthcare related partnership, association or corporation, nor is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees or governors of any other healthcare related business enterprise;

i) Applicant does not provide billing or collection services for any other professional person or organization;

j) If a sole practitioner, applicant does not share staff with any other professional person or organization;

k) If a sole practitioner, applicant does not share office premises with any psychiatrist or any other physician;

l) Applicant is not licensed or authorized to provide any other professional services except as stated in application;

m) Applicant has never had his/her license or certification revoked or suspended, nor been the subject of any disciplinary proceeding, nor been reprimanded by an administrative agency, professional association or peer committee;

n) Applicant has never had a claim or suit brought against him/her because of any alleged malpractice, error or mistake arising out of his/her professional services, and applicant is <u>not</u> aware of any circumstances which might result in such a claim or suit.

EXCEPTIONS, if any, to above (absence of entry means "no exceptions"). Please advise actual number of participants, or percentages where applicable: _____

_____ _____

Date Applicant Title