GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

Professional Liability Application for Mental Health Counseling Services / Clinics

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; if the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. INFORMATION

1.1 Applicant Name (including dba's): _____

Tax ID: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____)_____ Fax (_____)_____

Website: _____

1.6 Person to contact for Survey: Name: _____Title:_____

Email Address: _____

Telephone Number: _____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

A. The **APPLICANT** is an INDIVIDUAL. If so, the INDIVIDUAL is an:

☐ Employee (W-2) ☐ Student ☐ Ind. Contr. (1099) ☐ Sole Practitioner

B. The **APPLICANT** is a:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation

☐ Other - Describe:_____

1.9 Entity is ☐ For Profit ☐ Non-Profit, Describe source of funds: _____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if available): $_____

Is General Liability coverage also desired? ☐ Yes ☐ No

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Number of Patient Encounters: Next 12 months: _____ Last 12 months _____

1.14 Premises Square Footage Area occupied by applicant: _____

Are any off premises services provided? If yes, please describe: _____

_____

_____

PART II. EXPOSURES

2.1 Service is licensed as _____

_____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _____

_____

2.3 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction. _____

2.4 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration, or more than 25 patients/clients any one occasion? ☐ Yes ☐ No

If **YES**, give frequency and length of sessions, and # patients/clients:

(b) Does applicant conduct any seminars, workshops or other "group activities" away from regular office premises (including teaching seminars for fellow professionals). ☐ Yes ☐ No

If **YES**, give frequency of seminars and # participants/attendees. _____

_____

2.5 Does applicant sell, rent or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.) ☐ Yes ☐ No

If **YES**, please describe and give est. receipts.

_____

2.6 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients.

A) Hypno Therapy ☐ Yes ☐ No If yes, _____%

B) Biofeedback ☐ Yes ☐ No If yes, _____%

C) Kinesthetics ☐ Yes ☐ No If yes, _____%

D) Psychodrama ☐ Yes ☐ No If yes, _____%

E) Bioenergetics ☐ Yes ☐ No If yes, _____%

2.7 Does applicant routinely (more than twice in last three years) provide testimony in:

1) Child custody hearing ☐ Yes ☐ No If Yes, # times 3 yrs _____

2) Competency hearings ☐ Yes ☐ No If Yes, # times 3 yrs _____

3) As an expert witness in criminal or civil trials or other legal proceeding

☐ Yes ☐ No If Yes, # times 3 yrs _____

2.8 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying or apprehending criminal offenders? ☐ Yes ☐ No

If **YES**, please describe and give frequency _____

_____

2.9 Does applicant's practice involve the following: **(If Yes, give % of practice**, by income, hours or # clients)

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, _____%

2.10 Does applicant's practice involve the following: If **YES**, give % of practice, and number of clients treated in the last three years. Diagnosis / treatment of:

"Failed/Repressed" Memory Syndrome ☐ Yes ☐ No If Yes, _____% _____ # clients 3 yrs

Multiple Personality Disorder ☐ Yes ☐ No If Yes, _____% _____ # clients 3 yrs

2.11 Are any of applicant's patients/clients referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client? ☐ Yes ☐ No

If **YES**, give % of patients._____

2.12 **Unless otherwise noted hereunder**, the following are true statements with regard to the applicant:

a) Applicant, including employees and independent contractor, is not a principal with any 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 healthcare related business enterprise;

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

c) Applicant does not share staff with any other professional person or organization;

d) Applicant does not share office premises with any psychiatrist or any other physician;

e) Applicant, including employees and independent contractors, is not licensed or authorized to provide any other professional services except as stated in application;

f) Applicant, including employees and independent contractors, has never had his/her license or certification revoked or suspended, not been the subject of any disciplinary proceeding, not been reprimanded by an administrative agency, professional association or peer committee;

g) Applicant, including employees and independent contractors 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 not aware of any circumstances which might result in such a claim or suit.

EXCEPTIONS, if any, to above (absence of entry means "no exceptions"):_____

_____

PART III. RISK MANAGEMENT

3.1 Please list all professional staff including degrees held, professional designation:

a) Salaried Employees (W-2) _____

_____

_____

b) Independent Contractors (1099) _____

_____

_____

d) Professional Associates Sharing Premises _____

_____

_____

3.2 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ☐ Yes ☐ No

If **NO**, do you require contracted staff (if any) to carry their own Professional Liability Insurance? ☐ Yes ☐ No

Do you secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No

3.3 List all memberships in professional organizations. _____

_____

3.3 Do you enter into contractual agreements to provide professional services? ☐ Yes ☐ No

If **YES**, please enclose copies of all such contracts.

Do you provide services under contract, with said services billed by the other party in lieu of you billing direct for your services? ☐ Yes ☐ No

If **YES**, identify contract and services provided:

_____

_____

3.5 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ☐ Yes ☐ No

If not, are you agreeable to instituting this procedure? ☐ Yes ☐ No

ENCLOSE COPY OF YOUR LETTERHEAD, BROCHURES, AND/OR ADVERTISING.

PART IV. HISTORY

4.1 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	No
1.							
2.							
3.							
4.							
5.							

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

4.2 List prior general 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	No
1.							
2.							
3.							
4.							
5.							

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

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No

If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No

If yes, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant	Title

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Drug and Substance Abuse Testing Supplemental Questionnaire

1. Type specimens taken / tested:
   - ☐ Urine ☐ Blood
   - ☐ Other: Describe_____
2. Who does testing?
   - ☐ Insured's own laboratory / staff
   - ☐ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead results are sent out on)
   - ☐ Independent Laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead results sent out on)
3. Describe exactly who reads and interprets the test results:

   _____
4. Describe the "protocols" in place to prevent reporting of "false positive" results:

   _____

   _____
5. Describe the "policy" regarding "confidentially" of reports and records.

   _____

   _____
6. In the past year:
   (a) How many positive test results? _____
   (b) How many employees:
   (1) Treated? _____
   (2) Counseled? _____
   (3) Terminated from employment? _____
7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, include brochure if available.

   _____

   _____
8. Enclose copies of contracts between Insured and Client companies.

ADDENDUM TO MENTAL HEALTH PRACTITIONER'S APPLICATION
SUPERVISION OF OTHERS

Named Insured: _____

Fully describe the scope of your responsibilities as a ***supervisor***, including the percentage of your time spent in this capacity.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please provide the following information for each individual supervised:

NAME	POSITION	HOURS PER WEEK	COMPENSATED (Yes/No)	INSURED* (Yes/No)	# CONTACTS/WK
How are supervisee's hours billed to the client/patient?					
How does supervisee's patient profile differ from yours?					
Explain circumstances if supervisee is seeing patients away from your workplace.					

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* If insured, please attach certificate of insurance.