NATIONAL CHIROPRACTIC COUNCIL

Application *for* Membership

Contact and Practice Information:

Full Name (First, Middle, Last) _____ Practice / Clinic Name _____

Office Address (include Suite #) _____ City _____ State _____ Zip _____

Mailing Address – If Different from Office Address _____ City _____ State _____ Zip _____

Office Phone _____ Alternate Phone (Home, Cell, etc.) _____ Fax _____ Email _____

Chiropractic License Number(s) _____ State Issued _____ Date Issued _____ Chiropractic College and Location _____ Year Graduated _____

Social Security Number _____ Birth Date _____ Gender: ❒Male ❒Female

Fax or Mail Completed App & Payment to:

NCC Malprac
195 Mira Allende
San Clemente, CA 92673

Ph. 855-565-7722 Fax. 855-299-5122
email: rgreek@gmail.com

Payment Detail (See "Rate Sheet" for coverage choices):

Installment Due: ----------

Optional Arbitration Forms ($20 / pack) ----------

Optional Additional Insured (10%) ----------

Total Payment Remitted _____

Credit Card Payments, Complete Following:

Card Type: ❒ Visa ❒ MasterCard ❒ American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the National Chiropractic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

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Professional Information *(Attach Additional Sheets When Needed)*

1. Is your chiropractic license current? ❒Yes ❒No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *Yes*, attach explanation) ❒Yes ❒No
3. Has any agency or association ever investigated or taken any action against you or your license? (If *Yes*, attach explanation) ❒Yes ❒No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If *Yes*, attach explanation) ❒Yes ❒No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If *Yes*, attach explanation) ❒Yes ❒No
6. Have you been convicted of violating any law other than a minor traffic offense? (If *Yes*, attach explanation) ❒Yes ❒No
7. Do you ever use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness device? (If *Yes*, explain) ❒Yes ❒No
8. Do you practice obstetrics or colonics? (If *Yes*, attach explanation) ❒Yes ❒No
9. Do you treat cancer or epilepsy? (If *Yes*, attach explanation) ❒Yes ❒No
10. Do you ever perform, or intend to perform in the next year, manipulation under anesthesia? (An MUA addendum must be approved to activate MUA coverage.) ❒Yes ❒No
11. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If *Yes*, attach explanation) ❒Yes ❒No
12. Do you ever prescribe or dispense any prescription drugs? (If *Yes*, attach explanation) ❒Yes ❒No
13. Do you use any technique not taught in the chiropractic schools and colleges? (If *Yes*, attach explanation) ❒Yes ❒No
14. Do you <u>always</u> conduct comprehensive stroke screening prior to doing any cervical adjustment? ❒Yes ❒No
15. Do you make a differential diagnosis? ❒Yes ❒No *If No*, do you limit your responsibility to treating symptoms? ❒Yes ❒No
16. If the quality of an x-ray film is marginal, do you always do, or order, a retake? ❒Yes ❒No
17. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ❒Yes ❒No
18. Do you <u>always</u> require your patients to sign an informed consent prior to treatment? (If *Yes*, attach copy of form you use) ❒Yes ❒No
19. Do you <u>always</u> record the patient's account of his or her progress? ❒Yes ❒No ❒No, but I will do so now.
20. Do you <u>always</u> record objective findings? ❒Yes ❒No ❒No, but I will do so now.
21. Do you <u>always</u> record details of treatment procedures? ❒Yes ❒No ❒No, but I will do so now.
22. Do you refer to other health providers? ❒Yes ❒No *If Yes*, circle: MD Ortho Neuro DC RN RPT Other: _____
23. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____
24. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____
25. Do you treat Medicaid/Medi-Cal patients? ❒Yes ❒No *If Yes*, what % of your practice is Medicaid/Medi-Cal? _____
26. List any practice management company you have used *(If none, indicate so)*: _____
27. Do you ever collect fees for services before the day on which you provide those services? (If *Yes*, attach explanation) ❒Yes ❒No
28. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *Yes*, attach explanation) ❒Yes ❒No
29. Have you ever treated a person that was previously in a research program you sponsored? (If *Yes*, attach explanation) ❒Yes ❒No
30. Who provides your current chiropractic malpractice policy? _____ Expires: _____
31. Your Chiropractic insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
32. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): _____

    Indicate your malpractice carrier for that other profession: _____ Expires: _____
33. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

_____ _____ _____ _____

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34. Which best describes how you practice: ❒Sole Proprietor ❒Professional Corp. ❒Partnership ❒Employee ❒Contractor

35. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (10% cost), or separate limit (40% cost). Add sheets as needed:

_____ Limits: ❒Shared ❒Separate
Name of Additional Insured

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Name of Additional Insured

36. List any current chiropractic specialty designations / certifications held: _____

37. List any chiropractic awards, teaching appointments, or published works: _____

_____

38. If you have held hospital privileges or completed a residency, provide the following (Attach additional sheets if needed):

_____ _____ _____
Hospital Name and Location | Dates Affiliated | Nature of Privileges / Reason for Termination

39. List pre-chiropractic college education: _____ _____ _____
College | Yr Graduated | Degree

➢ Signatures - Member Application for Coverage *(Signatures are required in all **FOUR** places below)*

NO FALSE STATEMENTS: I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy.

1. Sign here: _____ **Date:** _____

CLAIMS-MADE ONLY ***(****Applies only if you selected a "Claims Made" Claims Reporting Basis):* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. Sign here: _____ **Date:** _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe chiropractic practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

3. Sign here: _____ **Date:** _____

RELEASE OF INFORMATION: I hereby authorize release of information from my professional chiropractic associations & organizations, any hospitals or insurance carriers, my State Board of Chiropractic Examiners, and any other relevant entity to: the National Chiropractic Council or its agent, for any underwriting or claim-related inquiry. I agree that the organization releasing such information shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

4. Sign here: _____ **Date:** _____