NATUROPATH MEMBERSHIP APPLICATION

Professional Information *(If you answer **YES** to any of questions 1 through 11, attach an explanation)*

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 Address
Naturopathic License Number(s)	State Issued	Date Issued	Naturopath School / College and Location	Year Graduated
Social Security Number	Birth Date	Sex: ❒Male ❒Female	

1. Is your naturopathic license current? ❒Yes ❒No
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees; or are you aware of any circumstance that could give rise to such a claim? (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 treat cancer or epilepsy? (If *Yes*, attach explanation) ❒Yes ❒No
8. Do you ever use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness Device? ❒Yes ❒No
9. Do you ever charge or collect fees before the day care is given, i.e. prepaid per case, on a contract, etc? ❒Yes ❒No
10. Do you ever use a collection agency with patients? ❒Yes ❒ No *If Yes*, are they authorized to sue to collect? ❒Yes ❒No
11. Have you (or an agency on your behalf) filed suit to collect sums due from patients? ❒Yes ❒No
12. Have you used a practice management company? ❒Yes ❒No *If Yes*, provide name:
13. Standard Modalities - Check each of the following treatment modalities you have used, or intend to use in your practice:

❒ Acupuncture [a]	❒ Diathermy	❒ Nutritional Therapy	❒ Ultrasound
❒ Behavioral [b]	❒ Electrical Stimulation	❒ Paracentesis	❒ Weight Control [c]
❒ Bio Feedback	❒ Homeopathy	❒ Physical Therapy	
❒ Botanical / Herbal Medicine	❒ Manipulation Therapy [a]	❒ Thoracentesis	

a *– A separate application addendum is required if you desire coverage to extend to either acupuncture or manipulation under anesthesia. Please request.* ***b*** *– Includes Counseling, Psychological Care, Stress Mgmt, etc.* ***c*** *- Other than diet and exercise*

14. Class II or Class III Modalities: Check any or all treatment modalities you have used, or intend to use in your practice:

❒ Cheletion Therapy (II or III)	❒ Hypnosis (III)	❒ Obstetrics / Deliveries (III)	❒ Prolo / Sclero Therapy (III)
❒ Colonoscopy (II)	❒ Needle Biopsies (II)	❒ Office surgery (II or III)	❒ Experimental/Other Therapy (II or III)
❒ Gynecology (II or III)	❒ Neonatal/Prenatal Care (II or III)	❒ Prescription Drugs (II or III)	

A separate application addendum must be completed and approved in order for coverage to extend to any Class II or Class III modalities. If applicable, please request an addendum promptly.

15. Do you use any technique or therapy that is not currently taught in the naturopathic schools and colleges? ❒Yes ❒No
If Yes, please list: _____

16. Do you accept Medi-Cal / Medicaid? ❒Yes ❒No *If Yes*, what % of your practice is Medi-Cal / Medicaid? _____ %

17. Do you make a differential diagnosis? ❒Yes ❒ No *If No*, do you limit your responsibility to treating symptoms? ❒Yes ❒No

18. Do you perform cervical adjustments? ❒Yes ❒No *If Yes*, do you regularly conduct stroke screening, i.e. the Georges Test, the Vertebral Artery Ischemia Test, the Cerebrovascular Cranio Cervical Function Test, etc.? (*If **NO***, please explain) ❒Yes ❒No

19. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ❒Yes ❒No

20. If the quality of an x-ray is marginal, do you always do (or order) a retake? ❒Yes ❒No

21. Do you refer to other providers? ❒Yes ❒No If *Yes*, circle: MD ND DO DPM DC L.Ac. RN RPT Other: _____

22. Do you always record the patient's account of his or her progress? ❒Yes ❒No ❒ No, but I will do so now.

23. Do you always record objective findings? ❒Yes ❒No ❒ No, but I will do so now.

24. Do you always record details of treatment procedures? ❒Yes ❒No ❒ No, but I will do so now.

25. Are you licensed to practice any other health care professions? ❒Yes ❒No
If Yes, please circle: MD, DO, DPM, DC, RN, RPT, Other _____
If Yes, name malpractice carrier for other profession: _____ Policy expires: _____

26. Which best describes your practice structure: ❒ Sole Proprietor ❒ Contractor ❒ Professional Corp ❒ Partnership ❒ Employee
List names of Entity, Partners, and / or Employers: _____

27. Do you wish coverage for your corporation, partnership or any other entity or person? (An additional charge applies) ❒Yes ❒No
If Yes, please print name(s): _____

28. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (attach additional sheets if necessary):

_____ _____

29. Number of patients you see weekly: _____ Number of hours per week in direct professional work with patients: _____

30. On what date would you like your coverage to be effective? (May not be before the date this application is received) _____

Signature – Application for Membership and Coverage

Declaration: I hereby apply for membership, and as indicated, coverage. I declare that the above statements are true and I have not suppressed or misstated any facts. I agree that this declaration shall be a basis for, and form a part of, my AINM membership and my professional liability policy. I understand untrue statements could void my AINM membership and / or my policy. 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. I understand that there is no guarantee that coverage will be renewed.

Claims Made Only: I understand that the policy for which I am applying provides coverage only for claims made during the policy period and arising out incidents which occurred subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even if the injury occurred while the policy was in force) unless the insured purchased an Extended Coverage Policy within 30 days after termination.

Release: I hereby authorize you to obtain from, or release to, any agency or organization, such personal or professional information as may be required by you to underwrite my insurance coverage or to thereafter maintain such coverage in force.

Sign here: _____ **Date:** _____