



## Naturopathic Physician Membership

**1. ASH Provider Information** (Please print neatly in black ink or type answers. Incomplete applications may be rejected.)

Full Name	Clinic Name			
Office Address (Premises Liability Location)	City	State	Zip	
Office Phone	Office Fax	Home Phone		
Naturopath License #	State Issued	Issue Date	Naturopath School Attended	Graduated On

**2. Professional Information** (If required, please provide any explanations on a separate sheet.)

1. Has any suit, arbitration, or other claim or proceeding been brought against you, your professional practice, associates, or employees for alleged malpractice? (If Yes, explain on separate sheet)  Yes  No
2. Do you know of any circumstances since your last application that would give rise to a claim being brought against you, your professional practice, associates or employees for professional malpractice? (If Yes, explain)  Yes  No
3. Has any agency investigated, suspended, revoked, or taken any action against your license to practice? (If Yes, explain)  Yes  No
4. Have you used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties; or used any illegal drug in the past year? (If Yes, explain)  Yes  No
5. Have you been convicted of violating any law or ordinance other than a minor traffic offense? (If Yes, explain)  Yes  No
6. Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association? (If Yes, explain)  Yes  No
7. Do you treat cancer or epilepsy? (If Yes, explain)  Yes  No
8. Do you ever use stressology, internal coccyx adjustment, magnetic therapy, 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? (If Yes, explain)  Yes  No
10. Do you ever use a collection agency with patients?  Yes  No If Yes, is the agency authorized to file suit to collect?  Yes  No
11. Have you (or an agency on your behalf) filed suit to collect sums due from patients? (If Yes, explain)  Yes  No
12. Have you used a practice management company?  Yes  No If Yes, provide name: \_\_\_\_\_
13. Do you use any technique or therapy that is not currently taught in the naturopathic schools and colleges?  Yes  No  
If Yes, please list: \_\_\_\_\_
14. Please check each of the following treatment modalities you have used, or intend to use in your practice:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Acupuncture <sup>a</sup>    | <input type="checkbox"/> Deliveries / Obstetrics | <input type="checkbox"/> Manipulation Therapy <sup>a</sup> | <input type="checkbox"/> Physical Therapy              |
| <input type="checkbox"/> Behavioral <sup>b</sup>     | <input type="checkbox"/> Diathermy               | <input type="checkbox"/> Needle Biopsies                   | <input type="checkbox"/> Prolo (sclero) Therapy        |
| <input type="checkbox"/> Bio Feedback                | <input type="checkbox"/> Electrical Stimulation  | <input type="checkbox"/> Neonatal /Prenatal Care           | <input type="checkbox"/> Thoracentesis                 |
| <input type="checkbox"/> Botanical / Herbal Medicine | <input type="checkbox"/> Experimental Procedures | <input type="checkbox"/> Nutritional Therapy               | <input type="checkbox"/> Ultrasound                    |
| <input type="checkbox"/> Cheleton Therapy            | <input type="checkbox"/> Homeopathy              | <input type="checkbox"/> Office surgery <sup>c</sup>       | <input type="checkbox"/> Weight Control <sup>d</sup>   |
| <input type="checkbox"/> Colonoscopy                 | <input type="checkbox"/> Hypnosis                | <input type="checkbox"/> Paracentesis                      | <input type="checkbox"/> Other (please attach details) |

a – A separate application addendum is required if you desire coverage to extend to either acupuncture or manipulation under anesthesia. Please request at once.  
b – Includes Counseling, Psychological Care, Stress Mgmt, etc. c - Includes I & D, skin sutures, removing warts, moles, cysts d - Other than diet and exercise

15. Do you ever prescribe or dispense any prescription drugs? (If Yes, explain)  Yes  No
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 use the Georges Test, the Vertebral Artery Ischemia Test, or the Cerebrovascular Cranio Cervical Function Test? (If No, please explain)  Yes  No

19. Does anyone x-ray patients other than: you, a qualified roentgenologist or radiologist, or other licensed x-ray technician? If Yes, please 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 patients to other doctors?  Yes  No If Yes, please 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 insurance company 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 of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (including naturopaths, acupuncturists, medical doctors, doctors of osteopathy, doctors of chiropractic, podiatrists, nurses, anesthetists, physical therapists, etc): Include name / practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT).  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**3. Signatures** (Signatures are required in three places.)

**NO FALSE STATEMENTS:** I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my professional liability insurance policy.

I understand that untrue statements could void my insurance policy. Sign: \_\_\_\_\_ .Date: \_\_\_\_\_

**CLAIMS-MADE ONLY:** 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. Sign: \_\_\_\_\_ .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 naturopathic practices may be based in part on information provided by me on future follow-up data sheets 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. Sign: \_\_\_\_\_ .Date: \_\_\_\_\_

**4. Choose Payment:**  \$1,125.00 (Annual)  \$306.00 (Quarterly)  
 (Rates are for the first year of a step rated program. The mature rate, at year 5, is \$3,400 annually.)

**5. Mail Application and Payment:**

**NCC Naturopath Program**  
 1851 East First Street, Suite 1160  
 Santa Ana, CA 92705  
 800.622.6869 • 714.571.1863 Fax

**To Pay by Credit Card, Complete the Following:**

Card #: \_\_\_\_\_ Expires: \_\_\_\_\_

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

Signature: \_\_\_\_\_