Curi

Underwritten by a Curi company:

MMIC Insurance, Inc. | UMIA Insurance, Inc.
Arkansas Mutual Insurance Company
MMIC Risk Retention Group, Inc.

curi.com

Treatment Centers Questionnaire

Instructions:

- This questionnaire must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments Section of this questionnaire or attach a separate sheet of paper.
- Coverage will not be considered until this questionnaire and the general application are completed and all required documents are provided.

Name of Applicant: _____
(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

Indicate the type of service(s) provided by the Applicant and complete the sections as instructed.

TYPE OF SERVICE	QUESTIONNAIRE INSTRUCTIONS
☐ College/University Health Center	Complete Sections A and B
☐ Community Health Center	Complete Sections A and B
☐ Convenience Care/Retail Clinic	Complete Sections A and B
☐ Municipal Health Department	Complete Sections A and B
☐ UrgiCenter	Complete Sections A and B
☐ Dialysis Center	Complete Sections A and C
☐ Oncology Services	Complete Sections A and C
☐ Medi-Spa	Complete Sections A and D
☐ Optical Establishment	Complete Sections A and E
☐ Sleep Lab	Complete Sections A and F
☐ Weight Loss Center	Complete Sections A and G

A. General Information

1. Specify where services are provided:

☐ Free Standing Facility ☐ Hospital ☐ Outpatient Facility
☐ Inpatient Facility ☐ Long Term Care Facility ☐ Physician Office
☐ Mobile Unit ☐ Other (specify): _____

2. Is overnight care provided? ☐ Yes ☐ No

If overnight care is provided, describe staffing levels, qualifications and patient to staff ratio:

3. Is the Applicant involved in any research activities? ☐ Yes ☐ No

If yes, please use the Comments section to explain.

B. College/University Health Center, Community Health Center, Convenience Care/Retail Clinic, Municipal Health Center, UrgiCenter

1. Does the Applicant provide any of the following services? Please indicate if not applicable: ☐ N/A

☐ Emergency Care ☐ Surgery ☐ Obstetrical Deliveries
☐ X-Ray/Imaging Services ☐ Pediatric Primary Health Care ☐ Abortions
☐ Invasive Procedures/Minor Surgery ☐ Prenatal Care ☐ Pharmacy
☐ Laboratory

2. Does the Applicant have a referral network for patients who are in need of further treatment? ☐ Yes ☐ No
3. Does the Applicant provide follow-up patient status calls? ☐ Yes ☐ No
4. Does the Applicant provide instructions for after-hours care? ☐ Yes ☐ No
5. Does the Applicant dispense controlled narcotics? ☐ Yes ☐ No

C. Dialysis Center and Oncology Services

1. What type of facility do you operate: ☐ Dialysis Center ☐ Oncology Services
2. Are employees properly trained to operate medical equipment? ☐ Yes ☐ No
3. Is equipment serviced by an in-house employee? ☐ Yes ☐ No
   If yes, is the employee trained to service the equipment? ☐ Yes ☐ No
4. Is equipment serviced by an outside vendor? ☐ Yes ☐ No
   If yes, does the contract for maintenance include a hold harmless indemnification clause? ☐ Yes ☐ No
   Do you require the vendor to carry professional liability insurance? ☐ Yes ☐ No
   If yes, what minimum limits of liability do you require them to carry? $ _____
5. Are user manuals available in-house for every piece of medical equipment? ☐ Yes ☐ No

D. Medi-Spa

1. What types of services are provided?

2. Indicate the type of lasers used, quantity and procedures performed.

Type of Laser	Quantity	Procedures Performed

3. Is the medical director involved in setting protocol? ☐ Yes ☐ No
4. Does the medical director review patient medical records? ☐ Yes ☐ No

E. Optical Establishment

1. Does the Applicant prescribe any pharmaceutical agents to patients for the treatment or management of eye disease or disorders? (Do not include pharmaceutical agents used for diagnostic procedures) ☐ Yes ☐ No

   If yes, describe:

2. Are surgical procedures performed? ☐ Yes ☐ No

   If yes, describe:

F. Sleep Lab

1. Do all professionals have a valid CPR certification? ☐ Yes ☐ No
2. What is the patient to staff ratio? _____
3. How many technicians are certified by the Board of Registered Polysomnographic Technologists? _____
4. Is there a mechanism to visually monitor and record patients during testing? ☐ Yes ☐ No
5. Do medically unstable patients have a nurse in attendance during the sleep study? ☐ Yes ☐ No
6. Do pediatric patients and patients who need assistance with daily living activities have a guardian or caregiver in attendance during the sleep study? ☐ Yes ☐ No
7. Are patients referred by a physician? ☐ Yes ☐ No
8. Who performs the screening prior to admitting a patient for a sleep study? _____
9. Does the Applicant have written policies and procedures for all technical procedures? ☐ Yes ☐ No
10. Does the Applicant provide overnight sleep studies? ☐ Yes ☐ No
    If yes, how many beds? _____

G. Weight Loss Center

1. Describe the types of services offered:

2. Are patients examined by a physician prior to starting any diet or exercise program? ☐ Yes ☐ No
3. Are services provided under the direction of a physician based on physician orders and plan of care? ☐ Yes ☐ No
4. Is there an exercise facility on site? ☐ Yes ☐ No
   If yes, is it open to the public? ☐ Yes ☐ No If yes, annual receipts: $_____
   Please describe the exercise facility in the Comments section including the equipment and classes available.
5. Does the Applicant sell vitamins, food supplements or beverages to patients? ☐ Yes ☐ No
   If yes, please describe in the Comments section including annual gross revenue.
6. Does the Applicant sell weight loss drugs? ☐ Yes ☐ No
   If yes, please describe in the Comments section including type and annual gross revenue.
7. Does the Applicant advocate the use of weight loss drugs? ☐ Yes ☐ No
   If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients and the types of drugs used.

H. Comments

Section and Question	Comments

Applicant Signature | Title | Date