Supplemental Questionnaire: **Palliative/ Pain Management**

Instructions:

1. This application must be completed in conjunction with the Pro-Praxis Allied Healthcare Application.
2. Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "n/a" in the appropriate space. Any spaces left blank will be interpreted to not apply.
3. This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Applicant Name: ____

1. Is your business ownership:
   ☐ Physician Owned ☐ Hospital Owned ☐ Independently Owned
   ☐ Other (specify): _____

2. Please identify the particular clinical practice guidelines adopted for your practice
   ☐ Indicate here if "none"
   ☐ American Pain Society ☐ American Society of Anesthesiologists
   ☐ American Academy of Family Physicians ☐ Other (specify): _____

3. Please provide the estimated number of procedures that will be performed over the next 12 months?

	Services	#Annually	Administered by MD	Administered by NP/PA	Administered by Other
☐	Hypnosis				
☐	Acupuncture				
☐	Physical Therapy				
☐	Prescription Medication				
☐	Only				
☐	Trigger Point Injections				
☐	MYBLOC/BOTOX Injections				
☐	Epidural Injections				
☐	Lumbar Sympathetic Nerve				
☐	Blocks				
☐	Intercostal Nerve Blocks				
☐	Sacroiliac Joint Injections				
☐	Facet Nerve Blocks				
☐	Stellate Ganglion Blocks				
☐	Other Nerve Blocks: (Type) ______________________ ______________________				
☐	Transcutaneous Electric				
☐	Nerve Stimulation (TENS)				
☐	Spinal Endoscopy				
☐	IntraDiscal Electric Thermal				
☐	Therapy				
☐	Radio Frequency Nerve				
☐	Ablation				

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☐	Bioelectric Treatment				
☐	Celiac Hypogastric Plexus				
☐	Injections				
☐	Spinal Cord Stimulation				
☐	Implantable Pain Control				
☐	Devices: (Type) ______________________ ______________________				
☐	Percutaneous Disc				
☐	Decompression				
☐	Vertebroplasty				
☐	Cryoanalgesia				
☐	Neurolytic Lysis of				
☐	Adhesions				
☐	Other: (Type) ______________________				
	TOTAL				

4. Do you:
   a. Accept walk-ins? ☐ Yes ☐ No ☐ n/a
   b. Require a referral from a current treating physician? ☐ Yes ☐ No ☐ n/a
   c. Administer anesthesia (other than topical) ☐ Yes ☐ No ☐ n/a
   d. Dispense controlled narcotics? ☐ Yes ☐ No ☐ n/a
   e. Dispense weight loss drugs? ☐ Yes ☐ No ☐ n/a
   f. Train employees to properly operate medical equipment? ☐ Yes ☐ No ☐ n/a
   g. Have a formal equipment maintenance program in place ? ☐ Yes ☐ No ☐ n/a
   h. Provide after-hours or in-home care? ☐ Yes ☐ No ☐ n/a
   i. Have an exercise facility on site? ☐ Yes ☐ No ☐ n/a
   *If yes, is it open to the public? ☐ Yes ☐ No ☐ n/a
   j. Perform any surgical procedures? ☐ Yes ☐ No ☐ n/a
   *If yes, explain: ____

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICANT'S NAME AND TITLE: ____

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APPLICANT'S SIGNATURE: ________________________ DATE: ________________________

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: ________________________ DATE: _________________________