TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company
Servicing Address: 29 Mill Street
Unionville, CT 06085

Medical Facility Liability Insurance Ambulatory Surgery Center and Pain Management Supplement

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1. Applicant Name identified in Medical Facility Application:

2. Indicate the total number of outpatient surgeries: Last 12 Months_____ Next 12 Months (Projected):_____

3. Please provide the number of procedures by category performed during the last 12 months and estimated for the next 12 months:

	Last 12 Months	Next 12 Months		Last 12 Months	Next 12 Months
Bariatric Surgery			Ophthalmology/Cataract		
Cardiovascular			Ophthalmology – Other		
Colon and Rectal			Orthopedic Surgery		
ENT			Pain Management		
Gastrointestinal Endoscopies			Plastic – Reconstructive		
General Surgery			Plastic – Cosmetic		
Gynecological			Podiatry		
Neuro Surgery/Spine			Radiation Oncology/Therapy		
Obstetrical			Urological		
Ophthalmology/Laser Eye			Vascular		

Note: If the Applicant has any procedures in the pain management category, please complete all of question 17.

4. Please describe any specific cosmetic procedures being performed:

5. Are any other services (other than surgery) not listed above (i.e. laboratory, imaging, office visits) provided? ☐Yes ☐No

   If "Yes," list service type and amount:

6. Does the Applicant perform any abortions? ☐Yes ☐No

   If "Yes," give number per year:

7. What percentage of the Applicant's patients/clients are under 18 years of age? _____%

8. Does the Applicant have any beds used for overnight capacity? ☐Yes ☐No

   If "Yes,"
   a. How many? _____
   b. Are any beds licensed as acute care hospital beds? ☐Yes ☐No
      If "Yes," how many? _____

9. Number of surgical suites/operating rooms: _____ Number of Recovery Rooms: _____

10. Does the Applicant provide any post-operative services? ☐Yes ☐No

If "Yes," please describe:

11. Please describe the provisions that have been made for the afterhours emergency:

Indicate which of the following equipment is maintained at the Applicant's facility:

☐EKG ☐Oxygen ☐Suction ☐Defibrillator

☐Crash cart with full cardiac life support capabilities and necessary IV fluids ☐X-Ray with ability to do on premises processing

12. Does the Applicant have written policies and procedures that address:

a. Documentation of preoperative care, intraoperative care and postoperative care? ☐Yes ☐No
b. Documentation of the performance of sponge and instrument counts in the medical record? ☐Yes ☐No
c. Dictation of operative report within 24 hours of surgery? ☐Yes ☐No
d. Phone call to the patient within 24 hours of discharge? ☐Yes ☐No
e. Documentation of patient notification of abnormal pathology results in the medical chart? ☐Yes ☐No

If "No" to any of the above, please explain:

13. Are equipment and instruments cleaned, disinfected and sterilized at the Applicant's facility? ☐Yes ☐No

If "No," who provides this service?

14. Does the Applicant have a written discharge policy in place that requires:

a. The patient be examined by a physician prior to discharge? ☐Yes ☐No
b. Written instructions (original maintained in the chart) including emergency care procedures be given to the patient upon discharge? ☐Yes ☐No
c. Someone other than the patient drives the patient home after the surgical procedures? ☐Yes ☐No

If "No" to any of the above, please explain:

15. Does the Applicant have a written emergency transport policy and an agreement with a local hospital? ☐Yes ☐No

Hospital Name_____ Hospital Address_____

Number of miles from the Applicant's facility _____

16. **Anesthesia**

Number of: Anesthesiologists _____ CRNAs _____

a. Are all anesthesiologists required to be board certified/eligible in anesthesiology? ☐Yes ☐No
b. Are all CRNAs supervised by an anesthesiologist? ☐Yes ☐No
c. Is a pre-anesthesia evaluation done by an anesthesiologist? ☐Yes ☐No
d. Is anesthesia equipment equipped with:
   i. Oxygen analyzers? ☐Yes ☐No
   ii. Disconnect alarms? ☐Yes ☐No
e. Who owns and maintains the oxygen equipment?
f. Is there a written process in place for patient selection (ASA criteria or other)? ☐Yes ☐No
g. Is there a separate informed consent for anesthesia? ☐Yes ☐No
h. Does the Applicant monitor the use of reversal agents? ☐Yes ☐No
i. Other than anesthesiologists or CRNA's, who administers anesthesia or conscious sedation?

17. **Pain Management**

a. What percentage of your practice is devoted to:

I. acute pain management? _____%

II. chronic pain management? _____%

b. Identify what percentage of your practice involves the following:

Lower Back/Spine	_____%	Degenerative Disc Disease	_____%
Arthritis	_____%	Cancer Pain	_____%
Crohn's Disease	_____%	Fibromyalgia	_____%
Headaches/Migraines	_____%	Jaw/TMJ	_____%
Other: _____	_____%		

c. Provide the number of procedures performed in your practice annually:

(**Note**: for Location of Procedure, answer "C" for Clinic, "H" for Hospital or "S" for Surgery Center)	Last 12 Months	Next 12 Months	Location of Procedure	Who Administers MD, PA, NP or other
Drug Treatment				
TENS				
Counseling				
Physical Therapy				
Acupuncture				
PCA Pumps				
Trigger Point Injections				
Nerve Blocks				
Facet Joint Blocks				
Epidural – non OB				
Chiropractic without Anesthesia				
Chiropractic Manipulation under Anesthesia				
Spinal cord stimulation				
Spinal drug delivery system				

d. Do you perform discography? ☐Yes ☐No

If "Yes," how many per year? _____

e. Do you administer anesthesia in the practice (other than topical)? ☐Yes ☐No

If "Yes," who administers? MD _☐__ CRNA __☐___

f. Do you require all patients to whom you prescribe controlled substances for chronic pain to sign an agreement or contract stipulating indications and risk for those medications and consequences of violating that agreement? ☐Yes ☐No

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	