



Allied Healthcare Professional Liability and General Liability:

MENTAL HEALTH COUNSELOR/THERAPY SERVICES SUPPLEMENTAL APPLICATION

1. Name of applicant: _____
2. Please indicate type of counseling services provided:

<input type="checkbox"/> Art therapy <input type="checkbox"/> Dance therapy <input type="checkbox"/> Drama therapy <input type="checkbox"/> Guidance counselor for schools <input type="checkbox"/> Horticultural therapy <input type="checkbox"/> Mental health counseling	<input type="checkbox"/> Music therapy <input type="checkbox"/> Pastoral/faith based counseling <input type="checkbox"/> Pet/animal assisted therapy <input type="checkbox"/> Recreational therapy <input type="checkbox"/> Wellness counseling
--	---
- Other: _____
3. List primary types of disorders treated: _____
4. Does applicant provide any form of recovered or repressed memory therapy? Yes No
5. Does applicant treat or provide any of the following? Yes No

<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Body disorder issues (Dysmorphic disorder, cutting, etc.)	<input type="checkbox"/> Eating disorder/obesity (for minors)
<input type="checkbox"/> Forensic psychologist/counselor	<input type="checkbox"/> Genetic counseling	<input type="checkbox"/> Paranoid/Schizophrenia personality disorder
<input type="checkbox"/> PTSD (post traumatic stress disorder)	<input type="checkbox"/> Severe depression counseling	<input type="checkbox"/> Sexual abuse (physical abuse)
		<input type="checkbox"/> Sexual offenders
6. Percentage of practice involved with treating minors who are victims of molestation, abuse or violence? _____%
7. Does applicant provide suicide counseling or crisis hotline services? Yes No
8. Does applicant provide perpetrator counseling whether or not the perpetrator is charged with or convicted of a crime? Yes No
9. Does applicant provide court appointed evaluations or counseling including counseling of persons on probation or parole? Yes No
10. Does applicant use hypnotherapy as a treatment modality? Yes No
11. Does applicant use shock therapy as a treatment modality? Yes No
12. Is applicant or facility staff certified in Cardio-Pulmonary Resuscitation (CPR) and first aid? Yes No
13. Does applicant provide abortion counseling, adoption screening or foster care screening? Yes No
14. Are any physicians, psychiatrists, pharmacists or nurses on staff? Yes No
15. Does applicant use animal assisted therapy treatment modalities? Yes No
 - a) Percentage of practice using Equine therapy?: ____%
 - b) Percentage of practice providing animal assisted treatment to minors?: ____%
16. Does applicant follow formal guidelines for referring clients/patients to specialists when appropriate? Yes No
17. Does applicant follow written policies and procedures to protect the confidentiality of client/patient files in compliance with HIPAA and federal and state privacy laws? Yes No

This supplemental application is incorporated into and is deemed a part of the other application(s) submitted in connection with the requested insurance. Any and all notices and representations included in such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Applicant's Signature _____ Title _____ Date _____
(Principal, Partner or Officer)

Print Name _____