Chiropractic Care of Minnesota, Inc.

Chiropractic Application for Network Participation

1. Name _____
   (as shown on license): Last (include Sr., Jr., III etc) First Middle
2. a. Gender: ___Male ___Female b. Birth date____ /____ /____ c. Social Security Number _____- _____ -_____
3. Please list all licenses in state(s) where you have been licensed and/or treated patients in the past five (5) years. ***If you need additional space, please use page 6:***
   Chiropractic License number: _____ State: _____ License Expiration Date___ /___ /___
   Chiropractic License number: _____ State: _____ License Expiration Date___ /___ /___
4. a. ___ Individual NPI Number:_____ ***(Required)***
   b. ___Organizational NPI Number:_____ ***(Required if W-9 indicates other than Individual/Sole Proprietor)***
   c. ___Medicare Number:_____ ***(Required)***
   d. ___Federal Tax Identification Number:_____
5. **Chiropractic College Education and Training**

School Name	Degree(s)	State	Dates Attended	Year Graduated

6. a. **Office Address**--List the address where patients will be treated. For all additional offices complete the attached *Satellite Office Application*:
   Clinic/Practice Name **(required)**:_____
   Street _____ Suite #_____
   City _____ County _____ State _____ Zip Code (+4)_____ - ____
   Day phone # ( )_____ Fax # ( )_____ ___ **None**
   E-mail address _____ Website address _____
   b. Do you submit claims electronically? (***Required in MN)*** ❑ Yes ❑ No
   c. Do you have any partners/associates at this location? ❑ Yes ❑ No
   d. If you answered, "Yes" above, please list your partners/associates below:

Last Name	First Name	Middle Initial	Specialty

7. Please indicate nearest cross streets: _____
8. Check all communication services available outside of normal business hours to direct patients in an emergency situation.
   ___After hrs. phone #( )_____ ___ Cell #( )_____ ___ Answering service
   ___Answering machine ___ No after hours service
9. Is your office located in a a. ___ Commercially zoned building b. ___ Home
   c. ___ Gym/health spa/salon d. ___ No office, I travel to clients
   Home office, gym, health spa, or salon only --
   Does the facility charge a fee in order to access chiropractic services? e. ___Yes ___No
   Do you have a separate room dedicated solely to providing chiropractic services? f. ___Yes ___No
   If you indicated "home", please answer the following:
   Do patients have to walk through any part of the living quarters? g. ___Yes ___No
   Is there a separate office entrance with signage? h. ___Yes ___No
10. **Billing Information**
    Address where payment is to be sent (if different than office address):
    Street or P.O. Box_____ Suite #_____
    City _____ County_____State _____ Zip Code (+4)_____ - _____

11. Please indicate the hours you are available to see patients each day.

	Mon. *(From/To)*	Tues. *(From/To)*	Wed. *(From/To)*	Thurs. *(From/To)*	Fri. *(From/To)*	Sat. *(From/To)*	Sun. *(From /To)*
A.M.							
Lunch							
P.M.							
Total hrs.							

12. Please indicate the average time interval between the time that a patient calls your office to schedule an appointment and when he/she is first seen by you.

a. Urgent patient: ___ within 24 hours ___ more than 24 hours
b. Non-urgent new patient: ___ five (5) business days or less ___ more than five (5) business days

13. Average number of patients you see daily: _____

14. Indicate the number of staff members (other than yourself) who are available to assist with checking patients in and/or patient care (e.g., check on patients, change face paper, place patients on tables, assist patients with equipment, apply or remove physiotherapy): _____

15. a. Are you able to proficiently read and write in the English language? ___ Yes ___ No
b. Check all languages you and/or your staff speak fluently:

	DC	Staff		DC	Staff		DC	Staff		DC	Staff
American Sign Language	___	___	German	___	___	Lao	___	___	Spanish	___	___
Cambodian	___	___	Hmong	___	___	Mandarin	___	___	Tagalog	___	___
Cantonese	___	___	Japanese	___	___	Portuguese	___	___	Vietnamese	___	___
French	___	___	Korean	___	___	Russian	___	___	Other _____	___	___

16. Indicate the number of: a. private treatment/exam rooms: _____ b. open bay: _____

17. Check any of the following areas in your office that are accessible to disabled persons:
a. ___ Office b. ___ Treatment room(s) c. ___ Rest rooms d. ___ Parking

18. Do you have x-ray equipment in your office? a. ___ Yes b. ___ No

19. Check all treatment techniques, modalities or devices used in your practice:

___ Activator	___ Cervical Drop Headpiece	___ Kale	___ Pro-Adjuster
___ Cox (Flexion/Distraction)	___ Cold Laser	___ Koren Specific	___ Straight
___ Diversified	___ Concept Therapy Institute	___ Logan Basic	___ Stressology
___ Extremity/Extravertebral	___ Contact Reflex Analysis	___ Manipulation Under Anesthesia	___ Sweat
___ Gonstead	___ Coupled Technique	___ Manual Adjusting	___ TMJ
___ Sacral Occipital Tech. (S.O.T.)	___ Cranial/Cranial Work	___ Meric	___ Terminal Point
___ Thompson (Drop Table)	___ Crane Technique	___ Motion Palpation	___ Toftness
___ Applied Kinesiology	___ DNFT	___ Network	___ Toggle Recoil
___ ASBE	___ DRX-9000/Vax-D	___ Neural Organization Tech.	___ Torque Release
___ Atlas Orthogonal	___ Full Spine	___ Net (Neuro Emotional Tech.)	___ Total Body Modification
___ Barge Analysis	___ Grostic	___ NUCCA	___ Upledger
___ BEST	___ Herbology	___ Non-Invasive Acupuncture	___ Van Rumpt
___ Biophysics	___ HIO (Hole in One)	___ Palmer Package	___ Vector Point Therapy
___ Blair	___ Homeopathy	___ Pettibon	___ Vertebral Axial Decompression
___ Carver Technique	___ Integrated Drop Table	___ Pierce/Pierce Stillwagon	___ Versendal
___ Other_____			

20. For the treatment techniques, modalities or devices you checked above, please indicate your primary, secondary and tertiary technique, modality or device along with its percentage of use in your practice. List any other techniques, modalities or devices used on the "Other" lines along with their percentage of use in your practice:

Primary: _____ Used_____% out of 100% of the Time
Secondary: _____ Used_____% out of 100% of the Time
Tertiary: _____ Used_____% out of 100% of the Time
Other: _____ Used_____% out of 100% of the Time
Other: _____ Used_____% out of 100% of the Time
Other: _____ Used_____% out of 100% of the Time
Total: *(not to exceed **100%**)*

21. Do you record on each visit the patient's account of:
    a. His or her progress? ___ Yes ___ No b. Details of treatment procedures? ___ Yes ___ No
    c. Objective findings? ___ Yes ___ No d. Follow-up plan? ___ Yes ___ No
22. Do you consider all possible causes of a patient's complaints including subluxations, or do you consider subluxations only?
    a. ___ All possible causes b. ___ Investigate subluxation(s) only
23. Do you treat non-neuromusculoskeletal conditions?
    ___ Yes ***If yes, please explain on page 6.***
    ___ No
24. Do you refer patients who are not improving with a trial of chiropractic care or with a non-neuromusculoskeletal condition or disease to a medical doctor?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
25. Do you perform:
    a. Breast exams? ___ Yes ___ No b. Gynecological exams? ___ Yes ___ No c. Prostate exams? ___ Yes ___ No
    d. Rectal exams? ___ Yes ___ No e. Colonic irrigations? ___ Yes ___ No f. Obstetrics? ___ Yes ___ No
    If you answered "Yes" to questions 25a through 25f, please explain on page 6.
26. Do you routinely perform vascular history and/or screening procedures prior to initiating a treatment plan of cervical manipulation?
    ___Yes
    ___No ***If no, please explain on page 6.***
27. Do you order x-rays for all patients?
    ___ Yes ***If yes, please explain on page 6.***
    ___ No
28. If the quality of an x-ray film is marginal, whether taken by you or another facility, do you always reshoot the x-rays or request they be retaken?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
29. Do you instruct your patients in home therapeutic exercises for neuromusculoskeletal conditions?
    ___ Yes
    ___ No ***If no, please explain on page 6.***
30. Check all current memberships/certifications in chiropractic-related specialty boards, academies or colleges, and indicate dates certified, inclusive of end dates:
    ___ **None** ___ Qualified Medical Evaluator (state appointed) ___ Independent Medical Examiner
    ___ Industrial Disability Examiner ___ Disability Evaluator ___ Other_____

Specialty Area	Certification No.	Date Certified	Expiration Date

31. **Work and Practice History**
    For the previous five (5) years up to the present, account for all work, practice and other activities including time spent in military service, previous practices, extended travel, etc. ***Please include <u>all</u> current practice locations***. List all in chronological order with date span, location and type of activity. If necessary, continue this listing on ***page 6*** of the application. ***For all gaps of six (6) months or greater, please provide an explanation on page 6 of the application.***

	From/To (month/year)	Location (list the address, city, state and zip code)	Type of Activity/Practice
1.	__/____ to **Present**		
2.	__/____ to __/____		
3.	__/____ to __/____		
4.	__/____ to __/____		
5.	__/____ to __/____		

32. **Physical and Mental Health Status**
Are you able to perform the activities for which you have requested the right to perform, with or without reasonable accommodations?

___Yes

___No ***If no, please explain on page 6.***

33. **Compliance with Laws Related to Patient Care**
Except for prior felony charges which did not result in a conviction, has any action ever been undertaken, whether formal or informal, still pending or completed, against you by any governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the practice of your profession or to your rendition of service to patients?

___Yes ***If yes, please explain on page 6.***

___No

34. **Chemical Dependency/Substance Abuse**
Do you currently use, or have you used within the last year, illegal drugs or prescription drugs without a prescription from a licensed physician?

___Yes ***If yes, please explain on page 6.***

___No

35. **Felony Convictions**
Have there ever been any felony convictions against you, except those for which records have been sealed or expunged, or are any felony charges pending against you?

___Yes ***If yes, please explain on page 6.***

___No

36. **Acknowledgments and Agreements**
Your signature on this application certifies to Chiropractic Care of Minnesota, Inc., and its clients (including HMOs, third party administrators and insurance carriers) your acknowledgment of and agreement to the following: You will truthfully report all relevant information to Chiropractic Care of Minnesota, Inc. as soon as possible if any of the events in the questions set forth above (re: "Physical and Mental Health Status," "Compliance with Laws Related to Patient Care," "Chemical Dependency/Substance Abuse" and "Felony Convictions") occur (i.e., if one of those questions must be answered contrary to your original answer) after you have signed and dated this form while your application is still pending and, if you are appointed, while you are a participant of Chiropractic Care of Minnesota, Inc.

Please initial: _____

37. **If you answer "Yes" to any of the following questions, give full details on the attached *Liability Claim Reporting Form*.**

a. Have any professional liability claims ever been filed against you, have you reported any liability claim to your insurance carrier, or have you ever received any letters of intent to sue?
___ Yes
___ No

b. Are any professional liability claims currently pending against you?
___ Yes
___ No

c. Has any judgment been made in any such professional liability case?
___ Yes
___ No

d. Has any settlement been made in any professional liability case in which you or your liability insurance carrier had to (or agreed to) make a monetary payment?
___Yes
___No

38. **Professional Liability Insurance**

a. Have you ever been denied professional liability insurance, has your policy been canceled, has your liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any liability carrier expressed any intent to deny, cancel, not renew, or limit your liability insurance or its coverage?

___Yes ***If yes, please explain on page 6.***
___No

b. Identify your professional liability (malpractice) insurer as requested below and attach proof that your current insurance coverage equals or exceeds minimum requirements for participation (see "Overview of Credentialing Guidelines").

Carrier_____Insurance Policy #_____Expiration Date___/___/___Policy Limits_____/_____

Street _____City_____ State _____Zip_____

39. **Actions or Pending Action Regarding Memberships, Privileges, Licensure and Certifications, and Contracting Programs**

Has any action, report reprimand, complaint or limitation ever been imposed on you, whether still pending or complete? This includes but is not limited to, any investigation, voluntary or involuntary surrender of license, membership or privileges, revocation, suspension, probationary action and/or impaired status as it pertains to your ability to practice. This voluntary surrender of privileges or membership unrelated to any pending or completed action or due to relocation does not need to be reported.

		Yes	No
a.	Your license or certificate to practice any profession in any country, state, or county?	___	___
b.	Any certifications related to chiropractic?	___	___
c.	Your privileges to practice within a hospital or clinical setting?	___	___
d.	Your affiliation with preferred provider programs, health maintenance organizations, Medicare, Medicaid, or other private, public or regulatory programs?	___	___
e.	Your status as a student in good standing in any internship, residency, fellowship, pre-ceptorship, or other clinical education program?	___	___
f.	Your membership or fellowship in any local, county, state, regional, national or inter-national professional organization?	___	___
g.	Your professional school faculty position or membership?	___	___

If you answered "Yes" to questions 39a through 39g, please give full details for each instance on page 6.

40. Authorization for Information Release

I authorize Chiropractic Care of Minnesota, Inc. to consult with, and obtain from, any and all individuals, educational institutions, the National Practitioner Data Bank, Federation of Chiropractic Licensing Boards, the Board of Chiropractic Examiners, Medicare/Medicaid, professional/trade associations, insurance companies, HMOs, PPOs and other organizations who can provide information bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others. I also authorize the release of information concerning my professional or general liability claims, if any. I release from liability both those individuals and organizations who have provided this information and Chiropractic Care of Minnesota, Inc. in using this information.

Signature _____ **Today's Date**_____

41. Attestation

You fully understand that any misstatements in or omissions from this application will constitute cause for denial of your application for participation, or termination of your participation agreement. You hereby affirm that the information furnished by you to Chiropractic Care of Minnesota, Inc. is true and complete to the best of your knowledge. You further understand and agree that acceptance of your application does not constitute appointment or continued appointment as a network participant in Chiropractic Care of Minnesota, Inc. until such time as you receive written notice of approval of the application and your correspondence confirming your appointment or reappointment as a participant in one of Chiropractic Care of Minnesota, Inc.'s state-specific networks.

Signature _____ **Today's Date**_____

Please note: A photocopy or facsimile of this document is considered an original.

Detailed Explanation Sheet

Please provide a detailed explanation if you answered "Yes" to questions 23, 25 "a-f", 27, 33, 34, 35, 38 "a" and/or 39 "a-g" or if you answered "No" to questions 24, 26, 28, 29 and/or 32. You may also use this form to provide additional information regarding questions 3 (licenses) and/or 31 (work history).

Question Number _____

Explanation _____

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Question Number _____

Explanation _____

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Question Number _____

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(If additional space is needed, please use a separate sheet)