



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:
3. List primary types of disorders treated:
4. Does the applicant provide any form of recovered or repressed memory therapy?
5. Does the applicant specialize (greater than 25% of services provided is considered specialization) in treatment of any of the following
6. Percentage of practice involved with treating minors who are victims of molestation, abuse or violence?
7. Does the applicant provide a suicide hotline service?
8. Does the applicant provide perpetrator counseling whether or not the perpetrator is charged with or convicted of a crime?
9. Does the applicant provide court appointed evaluations or counseling including counseling of persons on probation or parole?
10. Does the applicant use hypnotherapy as a treatment modality?
11. Does the applicant use shock therapy as a treatment modality?
12. Does the applicant provide abortion counseling, adoption screening or foster care screening?
13. Does the applicant use animal assisted therapy treatment modalities?
14. Does the applicant follow written policies and procedures to protect the confidentiality of client/patient files in compliance with HIPAA and federal and state privacy laws?

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: (Principal, Partner or Officer) Title: Date:
Print name: