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:
   - ❑ Art therapy
   - ❑ Dance therapy
   - ❑ Drama therapy
   - ❑ Guidance counselor for schools
   - ❑ Horticultural therapy
   - ❑ Mental health counseling
   - ❑ Music therapy
   - ❑ Pastoral/faith based counseling
   - ❑ Pet/animal assisted therapy
   - ❑ Recreational therapy
   - ❑ 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
   ❑ Bipolar disorder ❑ Body disorder issues (Dysmorphic disorder, cutting, etc.) ❑ Eating disorder/obesity (for minors)
   ❑ Forensic psychologist/counselor ❑ Genetic counseling ❑ Paranoid/Schizophrenia personality disorder
   ❑ PTSD (post traumatic stress disorder) ❑ Severe depression counseling ❑ Sexual abuse (physical abuse) ❑ 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 _____