

## COSMETIC PROCEDURES SUPPLEMENTAL QUESTIONNAIRE

Name (please print) \_\_\_\_\_

Policy Number (if currently insured with NORCAL) \_\_\_\_\_

**Directions:** Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 4.**

### SECTION I NONINVASIVE PROCEDURES

1. Please identify which of the following procedures you perform and provide the estimated number that you perform per year. **Also provide proof of training for each person that will perform these cosmetic procedures** and a copy of your consent form.

If you do not perform any of the procedures listed below, please check here and go to the Invasive Procedures section.

Procedure	Names and Designations of All Individuals Performing	Estimated Number Performed Per Year	If Performed by Non-physician Personnel, Does Physician Evaluate the Patient Before It Is Performed?
<input type="checkbox"/> Botox Injection			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bovine or Porcine Collagen Injections			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chemical Peel – AHA Solution Strength: _____ %			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chemical Peel – TCA Solution Strength: _____ %			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chemical Peel – Phenol			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chemical Peel – Other Specify Types and Solution Strength: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Collagen Injection			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Microdermabrasion			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dermabrasion			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dermaplaning			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Electrolysis			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hyaluronic Acid Injection			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Laser Hair Removal			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Laser Skin Resurfacing			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Permanent Makeup/ Micropigmentation			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No



## SECTION III MISCELLANEOUS

1. What percentage of your practice is devoted to Cosmetic Procedures? \_\_\_\_\_ %

2. Do you perform any procedure(s) not already specified on this questionnaire?

**If yes**, please identify the procedure(s) and the estimated number of each that you perform per year:

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3. Do you have hospital privileges for each procedure that you perform?  **Yes**  **No**

**If no**, please identify the procedures for which you do not maintain hospital privileges and explain:

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4. Do you perform cosmetic procedures on patients younger than 18 years of age?  **Yes**  **No**

**If yes**, please provide a list of procedures performed and your patient selection criteria:

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5. Do ancillary personnel perform any cosmetic procedures outside the supervising physician's practice?  
 **Yes**  **No**

**If yes**, please provide the location address and what type of supervision is provided.

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6. Please provide name and address of the location and the type of facility/location where cosmetic procedures are performed (for example, free-standing surgery center, office-based surgical suite, or office):

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## REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b):

Page Number	Section Number	Question Number	Remarks
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Please provide any additional information material to the risk that has not otherwise been addressed in this questionnaire:


## REPRESENTATIONS AND WARRANTIES

**NOTE:** "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained in this questionnaire.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name