

**Neuromusculoskeletal
Medicine/Osteopathic
Manipulative Medicine**

Supplemental
Questionnaire



INTRODUCTION

Your Full Name:

Policy Number:

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 2.**

SECTION I

PROCEDURES AND SERVICES

1. Please identify the percentage of your practice devoted to osteopathic manipulative treatment and the conditions that you treat with it:

2. Do you perform manipulations on patients under anesthesia or moderate/deep sedation? Yes No

If yes, please identify the locations where it is performed, the type(s) of anesthesia administered to the patients and the qualifications of the person(s) who provide the anesthesia:

3. Do you perform any procedures other than osteopathic manipulative treatment? Yes No

If yes, please identify the procedures and the number of each that you perform annually:

4. Do you prescribe medication? Yes No

If yes, please identify the frequency with which you prescribe, the circumstances under which you prescribe and the medical conditions that are treated with the medications:

5. Do you always refer a patient to his or her primary care physician if you discover a medical condition (other than conditions that you will treat with osteopathic manipulative treatments) during a physical examination? Yes No

6. Do you always inform each of your patients/potential patients that you cannot act as his or her primary care physician?

Yes No

If you answered no to question 5 or 6, please explain:

SECTION II**REMARKS**

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona 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 on this questionnaire.

Signature

Date

(mm/dd/yyyy)

Name (Print)