

# Psychiatry

## 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

## PSYCHIATRY

1. Do you perform electroconvulsive therapy?  Yes  No

If yes, please indicate where you perform it:

Hospital/Hospital Surgery Center

Other:

Accredited Surgery Center (nonhospital)\*

\* Please provide proof that this location is accredited by the AAAASF, AAAHC or similar type of organization, or proof that it is certified by Medicare as an ambulatory surgery center.

2. When you identify a nonpsychiatric problem in a patient without a primary care physician, do you:

a. Arrange for a referral to another physician for further evaluation?  Yes  No

b. Follow up to ensure that the patient has been seen for further evaluation?  Yes  No

If you answered no to either 2a or 2b, please explain:

3. Do you prescribe medication?  Yes  No

If yes, please complete the following:

a. Do you discuss the risks, benefits and alternatives of the medication with the patient before prescribing, and then document the patient's chart with the discussion and/or obtain written consent?  Yes  No

b. Do your records reflect what medication was prescribed, as well as the dosage and size of the prescription?  Yes  No

c. Do your records contain a complete list of all current medications and drugs taken by the patient?  Yes  No

If you answered no to either 3a, 3b or 3c, please explain:

d. Do you ever prescribe medication for a patient who has another professional (PHD, LFMCC, MSW, etc.) as his or her primary therapist?  Yes  No

If yes, do you periodically see the patient yourself?  Yes  No

If no, please explain:

4. Do you provide sex therapy?  Yes  No

If yes, please complete the following:

a. Do you provide sex therapy that involves physical contact with the patient?  Yes  No

If yes, please explain and provide a detailed description of the therapy provided:

b. Do you ever use a sex surrogate in your practice?  Yes  No

**SECTION I** (Cont'd)

**PSYCHIATRY**

If **yes**, please explain and identify the professional relationship maintained between you and the surrogate (i.e., employer-employee, independent contractor, etc.)

5. Please indicate how you are available to your patients at times other than scheduled appointments:

- Answering Service Exchange       Beeper/Pager
- Private/Cell Phone                       Call Group                       Other (please specify):

**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)