



APPLIED MEDICO-LEGAL SOLUTIONS  
RISK RETENTION GROUP, INC.

**INTEGRATIVE MEDICINE  
SUPPLEMENTAL APPLICATION**

# APPLIED MEDICO-LEGAL SOLUTIONS

## RISK RETENTION GROUP, INC.

### GENERAL INFORMATION

<b>First Name</b>	<b>Last Name</b>	<b>AMS Policy Number (if current AMS insured)</b>
<b>Office Phone</b>	<b>Mobile Phone</b>	<b>Email Address</b>
<b>Practice Address</b>		

<b>Effective Date of Integrative Services</b>	
<b>Please indicate your Primary Specialty of Practice:</b>	
<b>Please indicate any Sub-Specialty of Practice:</b>	

**Please note that the following practices require the submission of your utilized protocol and informed consent:**

- Chelation Therapy
- IV Infusion Therapy
- Nerve Block
- Prolotherapy (Including PRP)



## PRACTICE INFORMATION

Please check "yes" or "no" next to procedures and/or techniques used in your practice and complete the matrix where "yes" has been indicated:

Yes/No	Procedure and/or Technique	Projected Number of Treatments Performed Annually	Number of Treatments Performed Previous Year	Certification Obtained?	Protocol Used? (Please Attach)	Informed Consent Used? (Please Attach)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Acupuncture			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Sensitivity			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Colon Hydrotherapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Electromagnetic Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Reiki and Therapeutic Touch			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Telemedicine			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Thermography			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bioidentical Hormone Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chelation Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	High Pressure Hyperbaric Oxygen			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nerve Blocks/Pain Management			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Naturopathic Obstetrics			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Manipulation Under Anesthesia			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Neural Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxidation Therapy/Ozone Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolotherapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Platelet Rich Plasma Injection			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stem Cell Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	UV Light Blood Irradiation			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	IV Therapy/Infusion Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PRACTICE INFORMATION

Complete for all practice situations that apply to you:

<b>Bioidentical Hormone Therapy:</b>	
Are you certified by ABHRT?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you monitor and document blood tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you prescribe estriol or any product that includes estriol?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Chelation Therapy:</b>	
Are you certified by an approved accrediting body?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use Disodium EDTA products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you monitor and document levels via blood tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>High Pressure Hyperbaric Oxygen:</b>	
Do you use High Pressure Hyperbaric Oxygen Treatment for any diagnoses that are outside of the approved 14 diagnoses?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Oxidative Therapy/Ozone Therapy:</b>	
Do you offer full disclosure and informed consent regarding the therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use IV hydrogen peroxide?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Prolotherapy or Platelet Rich Plasma Injections:</b>	
Have you received post graduate training with certification for these procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Stem Cell Therapy:</b>	
Is your clinic certified by International Cellular Medicine Society?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any source of stem cells other than autologous bone marrow?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently use stem cell treatment to treat more than 5 specific disease processes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you inject stem cells IV for treatment of non-blood based diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PHARMACEUTICAL INFORMATION

**For any procedure and/or technique indicated "yes" in the section above, please complete the additional questions below:**

Do you use compounding pharmacies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the pharmacies you use accredited and licensed by their state?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do you personally compound any medications for patient use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in compliance with the US Pharmacopeia Convention (USP) guidelines?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PHYSICIAN CERTIFICATION

Incomplete or incorrect information could result in a retroactive upward premium adjustment or could lead to a denial of liability in the event of a claim. I also understand that any material misrepresentation or omission made by me on this application may render any contract of insurance null and without effect or provide the company with the right to rescind it.

I hereby declare that the statements and responses I have provided in this application are complete and true and that I have not knowingly suppressed or misstated any material facts. I agree to immediately notify the company in writing if there is any future material change in any answer to this application, including without limitation, any change in my professional status, specialty, affiliation, or working arrangement with any other physician, firm, or professional association, and I understand and agree that such changes are material to the risks covered by the policy of insurance I am applying for.

By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued. I understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) offered me a premium quote, and (3) received, as a precondition to coverage, the total premium due or, if the company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms, I will have no coverage for any claim under any policy of insurance for which I am applying.

## PRIVACY AGREEMENT

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

We agree as follows:

### A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, we may make any uses

of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement:

- (i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

### B. Our Obligations and Activities.



We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

**C. In addition to using the Protected Health Information to perform the services set forth above, we may:**

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45

C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

**GENERAL FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**ALABAMA FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**ARKANSAS FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**COLORADO FRAUD WARNING:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA FRAUD WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA FRAUD NOTICE WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**IDAHO FRAUD WARNING:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**KANSAS FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**KENTUCKY FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**LOUISIANA FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MAINE FRAUD WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**MARYLAND FRAUD WARNING:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MINNESOTA FRAUD WARNING:** A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW JERSEY FRAUD WARNING:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW MEXICO FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NEW YORK FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OHIO FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA FRAUD WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON FRAUD WARNING:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**PENNSYLVANIA FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**RHODE ISLAND FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**TENNESSEE FRAUD WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

**TEXAS FRAUD WARNING:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**VIRGINIA FRAUD WARNING:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**WASHINGTON FRAUD WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**WEST VIRGINIA FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

**By your signature, you indicate to all the rules and regulations set by  
Applied Medico-Legal Solutions Risk Retention Group, Inc.**

<b>Print Applicant Name:</b>	
<b>Applicant Signature:</b>	
<b>Date:</b>	/ /

**Please remit your completed application to:**

**Applied Medico-Legal Solutions Risk Retention Group, Inc.  
c/o AMS Management Group  
23 Route 31 North, Suite A-20  
Pennington, New Jersey 08534**

**Phone: 609-737-1154  
Toll-free 866-461-1221  
Fax: 609-737-1186**

