



FSMTA Colon Hydrotherapy Program Coverage Application



CONTACT AND PRACTICE INFORMATION:

Full Name (First, Middle, Last)				Practice / Clinic Name			
Office Address (include Suite #)			City		State	Zip	
Mailing Address – If Different from Office Address				City		State	Zip
Office Phone		Alternate Phone (Home, Cell, etc.)		Fax		Email	
Colon Hydrotherapy License / Certificate		State Issued	Date Issued	Colon Hydrotherapy School/Program		Hrs Training	Year Graduated
Social Security Number				Birth Date		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

PROFESSIONAL INFORMATION

1. Is your Colon Hydrotherapist Certificate issued by: State City N/A Is this Certificate current? (Attach Copy) Yes No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If Yes, explain) Yes No
3. Has any agency or association ever investigated or taken any action against you or your license / certificate? (If Yes, explain) Yes No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If Yes, explain) Yes No
5. Have you ever used any drug or substance that interfered with your ability to perform colonics duties? (If Yes, explain) Yes No
6. Have you ever been convicted of any violation of the law other than a minor traffic offense? (If Yes, explain) Yes No
7. Do you use colon hydrotherapy to treat any conditions, diseases or injuries, or do you make any diagnoses? (If Yes, explain) Yes No
8. Do you provide colonic services to anyone with cancer, hemorrhoids, bloody diarrhea, rectal abnormalities, or who is receiving treatment for their kidneys? (If Yes, explain) Yes No
9. Do you ever administer anesthesia or any prescription drug? (If Yes, explain) Yes No
10. Do you always require a person to sign an informed consent prior to receiving colonic services? Yes No No, but I will do so now
11. How many colonics clients do you treat / week? _____ How many colonic irrigations or procedures do you perform / week? _____
12. What is the maximum number of times you allow a single person to receive colonic irrigations in any 12 month period? _____
13. Do you ever provide colon hydrotherapy services to minors (persons under the age of 18)? Yes No
14. Do you ever collect fees for services before the day on which you provide those services? (If Yes, attach explanation) Yes No
15. Have you, or anyone on your behalf, ever sued a colonics client to collect fees? (If Yes, attach explanation) Yes No
16. Equipment - The following are questions about your colon hydrotherapy machine (the "Device"):
 - a. Does the Device have its own chemical sanitizing unit? Yes No
 - b. Does the Device have its own built-in water purification unit? Yes No
 - c. Is the Device approved by the FDA? Yes No If Yes, FDA approval number: _____
 - d. Does the Device have a disposable colonic reservoir, tube, and xp? Yes No
 - e. Does the Device have automatic temperature control with a temperature sensor? Yes No
 - f. Does the Device have an automatic back flow prevention sensor and an automatic pressure sensor? Yes No

PROFESSIONAL INFORMATION (Continued from Page 1)

17. Techniques / Practice Protocol

- a. Do you provide colon hydrotherapy services to persons who are in the seated position? (If Yes, explain) Yes No
- b. Before providing colon hydrotherapy, do you determine if the person has a history of bloody diarrhea, diverticulitis, colitis, ulcerative colitis, colon cancer, hemorrhoids, bleeding hemorrhoids, rectal fissures / abnormalities, or any kidney condition? Yes No
- If Yes, will you still provide colon hydrotherapy to a person with a history of one or more such conditions? (If Yes, explain) Yes No
- c. When providing colon hydrotherapy, do you ever cause anything other than purified water to be put into a person's colon? Yes No
- If Yes, list any other substances and explain the reason(s) for using each such substance (attach additional sheets if necessary):

Substance Used	Reason for use of substance
_____	_____
_____	_____

18. Training:

- a. Are you certified by the International Association for Colon Hydrotherapy? Yes No
- b. Have you completed a course of study in colon hydrotherapy that satisfies the requirements of the state licensing board in your state that licenses colon hydrotherapy services? Yes No
- If Yes: Identify the course of study: _____ List the number of hours that you attended the course: _____
- Identify the state licensing board that approves such course: _____
- c. Other than what you set forth in Question 18b, have you completed any other courses of study in colon hydrotherapy? Yes No
- If Yes: Identify the course of study: _____ List the number of hours that you attended the course: _____

19. a. Do you have a website? Yes No If Yes, provide web address: _____
- b. Do you provide colonic hydrotherapy advice or services on the World Wide Web? Yes No
- If Yes, please provide details: _____

20. Do you use promotional literature? (If Yes, attached a copy) Yes No

21. Which advertising media do you use? Newspaper Direct Mail T.V. Radio None (Check all that apply – Attach copies)

PAYMENT

Professional Colonics liability and Premises Liability Coverage

Massage Therapy Supplement @ \$25

Additional Insured @ \$15 / Entity

Total Payment Remitted

\$184.00

Payment Type: Check MasterCard Visa

AMEX Discover

Card #: _____ Exp: _____

FAX OR MAIL APPLICATION TO:



FSMTA COLONICS PROGRAM
 1870 Aloma Avenue Suite 260
 Winter Park FL 32789
 877-376- 8248 Phone 407-628-2042 Fax

AGREEMENT & SIGNATURE

\$1,000,000 / \$3,000,000 PROFESSIONAL LIABILITY COVERAGE

NO FALSE STATEMENTS: I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I declare that: 1) The above statements are true, and 2) I have not suppressed or misstated any facts. I agree that this declaration shall be a basis of the contract and form a part of my Colonics professional liability insurance policy. I understand untrue statements could void my insurance policy.

CLAIMS-MADE ONLY: I understand that if coverage is granted, the policy will only cover claims made during the policy period arising out of the rendering of or failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

SIGN: _____ **DATE:** _____