Breckenridge
an accretive company
3550 George Business Pkwy NW, Suite 305 Kennesaw, GA 30144

Cryotherapy Program – IV Therapy Supplemental

NAMED INSURED_____FEIN_____

1) Who performs the IV Therapies:

Name:	Yrs Exp	Licensing (i.e. EMT, LVN, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do these people all carry their own professional liability? _____
Are you anticipating providing their professional liability on this policy? _____
Do you perform background checks on these people, including licensing checks and disciplinary actions against their licensing? _____

2) Types of IVs (please check all that apply):
   a. ☐ Hydration/Saline
   b. Vitamins/OTC supplements – Please list:
      _____
      _____
      _____
   c. Pain Management
      _____
      _____
      _____
   d. Do you provide any weight loss injections or other weight loss treatments including but not limited to
      - Selmaglutide/Dulaglutide
        - Ozempic ◯ Yes ◯ No
        - Rybelsus ◯ Yes ◯ No
        - Wegovy ◯ Yes ◯ No
        - Trulicity ◯ Yes ◯ No
        - Other _____
      - Fen-Phen ◯ Yes ◯ No
      - HCG ◯ Yes ◯ No
      - Other Weight Loss drugs_____
      - Are you using any compounded weight-loss drugs? ◯ Yes ◯ No

        If yes to compounded weight loss drugs, please respond to the following:
        - What compounding pharmacy(s) are you using? _____
        - Does the compounding pharmacy provide you with a additional insured status on their products liability? ◯ Yes ◯ No What limit of liability do they carry? _____
          _____

- Please provide full list of all ingredients in the compound – inert and active _____

  _____

- How do your store the compounded drugs? Please provide full details_____

  _____

- Do you sell or otherwise provide any DIY "mix at home" kits for any weight loss drugs?

  _____

e. Other: _____

f. Please provide total gross annual revenues for all weight loss injections_____
_____

g. When using weight loss injections, please answer the following questions:
- Do you require additional health screening questions for weight loss treatments? ○ Yes ○ No
- Is there a medical director that reviews patient's charts? ○ Yes ○ No Please provide name/credentials _____

  _____

- Do you provide treatment to patients with BMI's below 30? ○ Yes ○ No
- Do you monitor patient's BMI every treatment? ○ Yes ○ No
- Do you monitor patient's weight and progress? ○ Yes ○ No
- Is there cessation plan for when a patient will cease or decrease dosages? ○ Yes ○ No
- What is the frequency of doses?
  - ○ Weekly
  - ○ Bi-Weekly
  - ○ Monthly
  - ○ Other _____
- What is the maximum dosage given in your facility? _____
- Do you have your patient sign an additional, expanded consent for treatment that informs them that use for weight loss may be an "off label" use of this drug and may have dangerous side effects when used off label and that lists out all potential side effects for on and off label use? ○ Yes ○ No
- Do you advise your patients to seek immediate medical attention if experiencing any side effects? ○ Yes ○ No
- Do you allow treatment for anyone under the age of 18? ○ Yes ○ No
- How long do you retain these expanded waivers? _____
- Does your center have procedures to comply with the Health Insurance Portability and Accountability Act (HIPAA)? ○ Yes ○ No
- Are clients informed, in writing, of these procedures? ○ Yes ○ No
- Are they required to sign/date and acknowledge receipt of these procedures? ○ Yes ○ No

h. Do any medications require a doctor's prescription per the FDA? If so, please provide details on protocols and who is prescribing. ○ Yes ○ No

_____
_____
_____

3) What is the youngest age that your center will provide IV services to? _____
4) Does your center have a medical director? _____ Do they need to be covered on this policy? _____

5) Do you obtain a signed informed consent warning of any/all potential allergies and adverse reactions from these services? _____ (Please provide copy)
6) Please describe your sterilization procedures for all equipment: _____
_____
_____

This application will become part of the policy as a warranty of exposures.

Signed: _____

Title: _____

Date: _____