

## **TO APPLY FOR MEMBERSHIP TO CAPSTONE AMERICA, LLC**

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Please read and complete your enclosed application packet. Please return the following with your application as soon as possible. We will be unable to process your application if any portion is incomplete. Please see the checklist below:

- \_\_\_\_\_ Provider Application (please complete and sign)
  - \_\_\_\_\_ Copy of Current State Chiropractic License
  - \_\_\_\_\_ Copy of Current Chiropractic Malpractice Cover Sheet  
(coverage of \$1,000,000/\$3,000,000)
  - \_\_\_\_\_ Completed Form W-9
  - \_\_\_\_\_ Curriculum Vitae (Resume)
  - \_\_\_\_\_ 1 Case Sanitized Record (see explanation on page 4 of application)
- Application Fee \$350\*  
\* We will request this fee once the Credentialing Committee has reviewed and approved your application

**Return to:**  
**Capstone America, LLC**  
**1067 West Alder Street**  
**P.O. Box 270599**  
**Louisville, CO 80027**  
**(303) 604-9797**  
**Fax: 303-604-9811**

**If you have any questions, please call (303) 604-9797**

# Capstone America, LLC Advanced Practice Chiropractic

## Chiropractic Provider Application/Credentialing

### Personal Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_  
SSN: \_\_\_\_\_ TIN: \_\_\_\_\_  
Practice Name: \_\_\_\_\_ Years in Active Practice: \_\_\_\_\_  
Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Billing Address (if different): \_\_\_\_\_

Size of clinic (square feet): \_\_\_\_\_ Number of exam rooms: \_\_\_\_\_ Number of treatment rooms: \_\_\_\_\_  
Years in practice: \_\_\_\_\_ Number of years at current address: \_\_\_\_\_

Do you have x-ray facilities on the premises? Yes No  
How old is the x-ray equipment and is the equipment regularly inspected? \_\_\_\_\_

Is your office handicap accessible? Yes No                      Do you have ample parking spaces? Yes No

Additional Office Address & Telephone #: \_\_\_\_\_  
National and state chiropractic affiliations: \_\_\_\_\_  
Elected positions: \_\_\_\_\_  
Volunteer positions: \_\_\_\_\_

### Clinical Practice:

Type of practice: \_\_\_ Sole Proprietorship \_\_\_ Professional Corporation \_\_\_ Partnership \_\_\_ Office Sharing  
Arrangement. If office sharing, what other type(s) of health care professionals share the office?

\_\_\_\_\_

What days and hours do you work in the office seeing patients? \_\_\_\_\_  
How many patients do you see on an average day & week? \_\_\_\_\_ How many new pts/day/week: \_\_\_\_\_  
How much face to face time do you spend on average with each new patient and established  
patient/visit? \_\_\_\_\_  
Do you have an associate doctor? Yes No How many associate doctors do you employ? \_\_\_\_\_  
How many patients does the associate doctor see on an average day and week? \_\_\_\_\_

Please list the type(s) of paraprofessionals that you employ, or that share office space with you:  
\_\_\_\_\_

Do you own or refer your patients for static paraspinal surface EMG and/or thermal scans ? Yes No If yes,  
please explain what role these tools play in your diagnosis and patient management? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If applicable, describe adjunctive diagnostic tests that you commonly order in addition to physical  
examination: \_\_\_\_\_

Do you use objective outcome assessment tools in your practice? Y N If yes, what role do these tools play in your patient evaluation and management? \_\_\_\_\_  
\_\_\_\_\_

Describe the treatment modalities/procedures that you commonly employ in treatment of benign musculoskeletal conditions: \_\_\_\_\_  
\_\_\_\_\_

Do you routinely utilize passive modalities, i.e. hot packs, muscle stimulation, intersegmental traction, etc., in your patient care? If so, what protocol and time frames do you utilize these modalities for? \_\_\_\_\_  
\_\_\_\_\_

What is the average duration of care and number of patient visits for a typical trauma injured patient in your office? \_\_\_\_\_

What is the average duration of care and number of patient visits for a group health insured or cash paying patient in your office? \_\_\_\_\_

Do you routinely implement patient exercise or self-help activities in your management of patients? Yes No Please describe the types of exercise or self-management protocol you utilize: \_\_\_\_\_  
\_\_\_\_\_

What spinal manipulative procedures do you use to treat patients? \_\_\_\_\_  
\_\_\_\_\_

Do you receive patient referrals from nurse case managers on a regular basis? Yes No If Yes, how often do you receive auto or workers compensation related patient referrals?: \_\_\_\_\_

What are your primary new patient referral sources? \_\_\_\_\_  
\_\_\_\_\_

Please rate the percentage of each patient category that your practice has seen over the past six months:  
Cash patients: \_\_\_\_\_ Motor vehicle accident patients: \_\_\_\_\_  
Group health insurance: \_\_\_\_\_ Workers compensation patients: \_\_\_\_\_

In auto or workers compensation patients what percentage of these patients miss more than a week of work? \_\_\_\_\_ For these same patients, what percent have permanent residual injury at the conclusion of your treatment? \_\_\_\_\_

In your patients that fail to respond adequately to treatment, what do you see as common barriers to recovery? \_\_\_\_\_

Do you routinely transition patients from acute care to maintenance chiropractic care? Yes No If so, what percentage of your patient base is maintenance patients? \_\_\_\_\_

What percentage of your patients have you referred to physiatrists, orthopedists or neurologists in the past six months? \_\_\_\_\_

How long do you typically treat a patient before making these referrals? \_\_\_\_\_

Do you utilize in your practice or refer your patients on a regular basis for any of the following (check all that apply):

massage therapy                       foot orthotics                       acupuncture

applied kinesiology    Network chiropractic                       nutritional supplies                       magnet therapy

Ayurvedic medicine    craniosacral therapy

List other commonly utilized services: \_\_\_\_\_

List peer reviewed journals and other chiropractic/medical journals that you subscribe to and regularly read:

\_\_\_\_\_

\_\_\_\_\_

**History of Education & Professional Training and Experience**

High school graduated from and year of graduation: \_\_\_\_\_

College(s) attended and time frame: \_\_\_\_\_

Chiropractic college attended and graduation date: \_\_\_\_\_

Post-graduate education in the past three years: \_\_\_\_\_

\_\_\_\_\_

Advanced degrees obtained: \_\_\_\_\_

Professional work experience for past five years: \_\_\_\_\_

\_\_\_\_\_

States licensed to practice chiropractic:

_____	_____	_____	_____
State	License #	State	License #
_____	_____	_____	_____
State	License #	State	License #

**NOTE:** Include copy of your chiropractic license for the state(s) you practice in.

**Professional Malpractice, Sanctions, Penalties, Investigation Explanation**

Please provide all relevant information pertaining to any complaints, investigations or sanctions against your license or practice.

Complaint filed to:  Chiropractic Board of Examiners    Malpractice Carrier

Date of complaint or alleged incident: \_\_\_\_\_                      Filed by whom: \_\_\_\_\_

Nature of complaint: \_\_\_\_\_

Did your professional liability/malpractice carrier in this matter defend you? Yes No

Was there a settlement obtained? Yes No                      Is there a pending settlement? Yes No

Liability Carrier when alleged incident occurred? \_\_\_\_\_

If you have had any additional complaints filed against you please provide the above information on a separate sheet of paper.

**Clinical Case Management**

We are interested in knowing more about how you manage your patients. On separate paper please write your responses as to how you would manage the patients presented below. We are particularly interested in your diagnostic, clinical and case management skills. Furthermore, please describe in detail how you would evaluate these patients, possible referral situations and types of patient information and evaluation findings you would utilize to monitor your patient’s status and response to treatment. Also, we are interested in specific treatment protocols that you may use in these situations.

1. A 25-y.o. divorced mother of two young children presents following a low speed rear end parking lot collision. No initial report of injury was made, but she presents to you one week later legally

represented reporting constant intense nonradicular pain of a generalized nature involving the entire posterior neck and back. Prior medical history includes poor sleep, fatigue and lethargy and depressed affect of several year duration for which she has received no treatment. This patient has no social support or family support, is involved in no exercise or enjoyable recreational activities.

2. A 47-y.o. male presents with acute onset of the worst headache he has ever had. This headache presents secondary to weight lifting. Patient has new onset of slurred speech, and reports some discoordination.
3. A 50-y.o. female presents with chronic history of polysomatic complaints. She hurts every day all day with pains of various intensities migrating throughout her body. She reports to being mildly depressed, is moderately overweight, sedentary, has no joy in life and has seen many prior medical physicians and therapists without lasting benefit.

***Please submit one complete copy of a sanitized patient file of a patient that you have recently completed treatment for auto or work related injuries.***

***Please attach current resume, state chiropractic license, completed W-9 form (attached) and malpractice coverage declaration sheet (you must have \$1,000,000/\$3,000,000 malpractice coverage).***

***Please include a business check made out to Capstone Chiropractic Network, LLC for the credentialing fee.***

*Mail all information to: Capstone America, LLC  
Attn: Membership Committee  
1067 West Alder Street  
P.O. Box 270599  
Louisville, CO 80027*

The below signature confirms that he/she has provided information contained in this document that is true and complete. The below undersigned agrees to inform Capstone America, LLC of any changes to the information sought in this document. The below undersigned agrees to hold harmless Capstone America, LLC or any of their representative agents and/or health plans contracted with CCN.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

## Disclosure Statement

Instructions: Answer all questions. For any positive or “Yes” response, please provide a complete explanation on a separate paper.

### **Pertaining to your License:**

1.  Yes  No Has your license to practice chiropractic ever been denied, suspended, revoked, restricted, voluntarily surrendered or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?
2.  Yes  No Have you ever received a reprimand or been fined by a state licensing board?

### **Hospital Privileges and other Affiliations:**

3.  Yes  No Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organization (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
4.  Yes  No Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board)?
5.  Yes  No Have you voluntarily surrendered, limited your privileges or not reapplied for privileges?

### **Educational, Training and Board Certification:**

6.  Yes  No Were you ever placed on probation, disciplined, formally reprimanded, suspected or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
7.  Yes  No Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
8.  Yes  No Have any of your board certifications or eligibility ever been revoked?
9.  Yes  No Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

### **Medicare, Medicaid or other Governmental Program Participation:**

11.  Yes  No Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental healthcare plans or programs?

### **Other Sanctions or Investigations:**

12.  Yes  No Are you currently or have you ever been the subject of an investigation by a hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?
13.  Yes  No To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
14.  Yes  No Have you ever received sanctions from or been the subject of investigation by a regulatory agencies (i.e., OSHA, CLIA, etc.)?
15.  Yes  No Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct?
16.  Yes  No Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

### **Professional Liability Insurance Information and Claims History:**

17.  Yes  No Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
18.  Yes  No Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty by your professional liability insurance carrier, based on your individual liability history?

## Disclosure Questions, continued

19.  Yes  No Have you ever had any malpractice actions (pending, dropped, dismissed, arbitrated, mediated or litigated)? If yes, you must under separate cover provide a detailed accounting to include the name of the complainant, date of the alleged incident, results of investigations and any settlement for each malpractice claim.

### **Criminal/Civil History:**

20.  Yes  No Have you ever been convicted of, pled guilty to, or pled no contest to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical/chiropractic professional?
21.  Yes  No Have you ever been convicted of, pled guilty to, or pled no contest to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
22.  Yes  No Have you ever been court-martialed for actions related to your duties as a medical/chiropractor professional?

### **Ability to Perform Job:**

23.  Yes  No Are you currently engaged in the illegal use of drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine/chiropractic. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate that individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possessions or distribution is unlawful under the Controlled Substances Act or other provision of Federal law.” The term does include, however, the unlawful use of prescription controlled substances.)
24.  Yes  No Do you use any chemical substances that would in any way impair or limit your ability to practice medicine/chiropractic and perform the functions of your job with reasonable skill and safely?
25.  Yes  No Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?
26.  Yes  No Are you unable to perform the essential functions of a chiropractic practitioner in your area of practice even with reasonable accommodation?

**Certification, Releases and Signatures**

I certify that all information contained in this application and all its attachments is accurate, complete and true.

I understand that:

1. Any misrepresentation, misstatement or omission of a relevant fact in connection with the application may result in denial of my application or termination of my participation in Capstone America, LLC, hereafter (“Capstone”), and/or health plans contracted with Capstone.
2. It is my responsibility to promptly advise Capstone of any changes or additions to the information contained in this application.
3. All the information contained in this application or its attachments is subject to investigation by Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents.
4. This is an application only and my submission of this application does not automatically result in participation with Capstone and/or health plans contracted with Capstone, and;
5. In the event my application is rejected for reasons pertaining to professional conduct or competence, I understand that Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents may be obligated to report such information to the state licensing board and/or the National Practitioner Data Bank.

I authorize Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents, to consult with and obtain information from administrators and members or the medical staffs of clinics, rehabilitation centers, hospitals or institutions with which I have been or am currently associated, and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by representatives of Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I authorize Capstone or its designated agents to release my credentialing information, which it has on file, to Capstone contracted health plans or their designated agents.

I release from liability all representatives of Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I release from liability any and all individuals and organizations that, in good faith and without malice, provide information to Capstone, or its designated agents and/or health plans contracted with Capstone or their designated agents, concerning my professional competence, character or ethics. I consent to release and exchange of information relating to any disciplinary action, suspension or curtailment of medical-surgical privileges to AMI or its designated agents and/or health plans contracted with Capstone or their designated agents. I authorize the medical societies of which I am a member to provide Capstone or its designated agents and/or health plans contracted with Capstone or their designated agents, a copy of my application for membership and all related documents.

If I am accepted for participation in Capstone, I consent to Capstone’s or its designated agents and/or health plans contracted with Capstone or their agents inspection of my patient records and office as necessary for their peer, quality, and utilization review purposes. I also agree to be bound by Capstone’s and/or health plans contracted with Capstone, participation agreement, credentialing plan, quality assurance/utilization review plan and provider manual.

A photocopy of this document shall be as effective as the original.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name