

Application *for* Membership



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	
Acupuncture License Number(s)	State Issued	Date Issued	Acupuncture College and Location	Year Graduated
Social Security Number		Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Mail or Fax Your Completed Application To:

Scott Danahy Naylor

Insurance Brokers
 300 Spindrift Drive
 Amherst, NY 14221
www.sdnins.com
 Phone: 800-728-6362
 Fax: 716-634-2908
 email: acupl@sdnins.com

Payment Detail (See Coverage Options page for choices):

Installment Due:

Optional Arbitration Forms (\$20/pack)

Optional Additional Insured (10% or 40%)

Total Payment Remitted _____

Credit Card Payments, Complete Following:

Card Type: Visa MasterCard American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the American Acupuncture Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

AMERICAN ACUPUNCTURE COUNCIL

Membership Application

Professional Information (Attach Additional Sheets When Needed)

1. Is your acupuncture License current? Yes No
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees; or In the last three years has anyone asserted that your care, treatment or diagnosis was deficient or caused them harm? (If Yes, explain) Yes No
3. Has any agency or association ever investigated or taken any action against you or your license? (If Yes, attach explanation) Yes No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If Yes, attach explanation) Yes No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If Yes, attach explanation) Yes No
6. Have you been convicted of violating any law other than a minor traffic offense? (If Yes, attach explanation) Yes No
7. Do you treat cancer or epilepsy? (If Yes, attach explanation) Yes No
8. Do you practice obstetrics or colonics? (If Yes, attach explanation) Yes No
9. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If Yes, attach explanation) Yes No
10. Do you ever prescribe or dispense any prescription drugs? (If Yes, attach explanation) Yes No
11. Do you always maintain the needle shaft in a sterile state prior to insertion? (e.g. after removing a needle from sterile packaging) Yes No
12. Do you use disposable needles? Yes No If Yes, do you use them for one insertion only, then throw them away? Yes No
13. Do you ever use reusable needles? Yes No If Yes, do you always follow state guidelines for sterilization of needles? Yes No
14. Are your needles approved by the U.S. Food and Drug Administration? Yes No
15. Do you use any technique not currently taught in the acupuncture schools and colleges? (If Yes, attach explanation) Yes No
16. Do you make a differential diagnosis? Yes No If No, do you limit your responsibility to treating symptoms? Yes No
17. Do you always require your patients to sign an informed consent prior to treatment? (If Yes, attach a copy of the form you use) Yes No
18. Do you always record the patient's account of his or her progress? Yes No No, but I will do so now.
19. Do you always record objective findings? Yes No No, but I will do so now.
20. Do you always record details of treatment procedures? Yes No No, but I will do so now.
21. Do you refer to other health providers? Yes No If Yes, circle: MD Ortho Neuro DC RN RPT Other: _____
22. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____
23. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____
24. Do you treat Medicaid/Medi-Cal patients? Yes No If Yes, what % of your practice is Medicaid/Medi-Cal? _____
25. List any practice management company you have used (If none, indicate so): _____
26. Do you ever collect fees for services before the day on which you provide those services? (If Yes, attach explanation) Yes No
27. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If Yes, attach explanation) Yes No
28. Have you ever treated a person that was previously in a research program you sponsored? (If Yes, attach explanation) Yes No
29. Who provides your current acupuncture malpractice policy? _____ Expires: _____
30. Your Acupuncture insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
31. List any other professional healthcare license you hold (M.D., D.C., RN, RPT, etc.): _____
Indicate your malpractice carrier for that other profession: _____ Expires: _____
32. Which best describes how you practice: Sole Proprietor Professional Corp. Partnership Employee Contractor
33. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (10% cost), or separate limit (40% cost). Add sheets as needed:

Name of Additional Insured Limits: Shared Separate _____ Name of Additional Insured Limits: Shared Separate

AMERICAN ACUPUNCTURE COUNCIL

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34. Provide the names and practice type (ND, L.Ac., MD, DO, DC., DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

35. List any current acupuncture specialty designations / certifications held: _____

36. List any acupuncture awards, teaching appointments, or published works: _____

37. If you have held hospital privileges or completed a residency, provide the following (Attach additional sheets if needed):

Hospital Name and Location	Dates Affiliated	Nature of Privileges / Reason for Termination
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38. List pre-acupuncture college education: _____

College	Yr Graduated	Degree
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➤ **Signatures – Member Application for Coverage** (*Signatures are required in all **FOUR** places below*)

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my malpractice insurance policy. I understand that untrue statements could void my insurance policy.

1. **Sign here:** _____ **Date:** _____

CLAIMS-MADE ONLY (*Does not apply if your Claims Reporting Basis is Occurrence*): I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. **Sign here:** _____ **Date:** _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe acupuncture practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. 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.

3. **Sign here:** _____ **Date:** _____

RELEASE OF INFORMATION: I hereby authorize release and exchange of information from my professional acupuncture associations & organizations any hospitals or insurance carriers, my State Board of Acupuncture Examiners, and any other relevant entity to: the American Acupuncture Council or its agent. I agree that the organization releasing such information shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

4. **Sign here:** _____ **Date:** _____