



# Membership Application

Please complete the following:

|     |   |                      |                    |
|-----|---|----------------------|--------------------|
| 1.  | _____                                     |                      |                    |
|     | Last Name                                 | First Name           | Middle Name        |
| 2.  | _____                                     |                      |                    |
|     | Clinic Name                               |                      |                    |
| 3.  | _____                                     |                      |                    |
|     | Office Address                            | City                 | State Zip          |
| 4.  | _____                                     |                      |                    |
|     | Office Phone No.                          | Fax No.              | Home Phone No.     |
| 5.  | _____                                     |                      |                    |
|     | Mailing Address (If different from above) | City                 | State Zip          |
| 6.  | _____                                     | 7. / /               | 8. M F             |
|     | Social Security Number                    | Birthdate            | Sex                |
| 9.  | _____                                     | 10.                  | 11.                |
|     | Acupuncture License Number(s)             | State(s) Issued      | Date First Issued  |
| 12. | _____                                     | 13.                  | _____              |
|     | Acupuncture College or University         | City, State, Country | Year of Graduation |
| 13. | _____                                     |                      |                    |
|     | Email Address                             |                      |                    |

Please go on to pages 2 through 4 and then complete the payment information below:

|  |  |
|--|--|
| <p><b>Mail or Fax Your Completed Application To:</b></p> <p><b>Scott Danahy Naylor</b><br/>         300 Spindrift Drive<br/>         Amherst, NY 14221<br/>         Ph: 800-728-6362 Fax: 716-633-7141<br/> <a href="http://www.scottdanahynaylor.com">www.scottdanahynaylor.com</a><br/>         email: acupl@scottdanahynaylor.com</p> <p><b>Amount Remitted (Check or Credit Card)</b></p> <p>Installment Due (See page 5 of app): _____</p> <p>Arbitration Forms (\$20 / set): _____</p> <p><b>TOTAL REMITTED:</b> _____</p> | <p><b>Credit Card Authorization (Visa, MasterCard, American Express)</b></p> <p>Card #: _____</p> <p>Expires: _____</p> <p>You are hereby authorized to charge the above referenced card for the amount indicated (to the left) as required to activate my coverage through the American Acupuncture Council. I agree to pay this amount according to the terms of the card issuer agreement.</p> <p>Signature _____</p> |
|--|--|

# Membership Application



➤ **Please complete the following:**

1. Has any suit, arbitration, or other claim or proceeding been brought against you, your acupuncture partnership, your acupuncture corporation, associates, or employees for alleged malpractice?  
 **Yes**    **No**      If YES, give full details on a separate sheet.
2. Do you know of any circumstances that would give rise to a claim being brought against you, your acupuncture partnership, your acupuncture corporation, associates or employees for professional malpractice?  
 **Yes**    **No**      If YES, explain on a separate sheet.
3. Has any government agency investigated, suspended, revoked, or taken any other action against your license to practice?  
 **Yes**    **No**      If YES, explain on a separate sheet.
4. Have you ever had professional liability insurance refused, declined, canceled or accepted on special terms?  
 **Yes**    **No**      If YES, give full details on a separate sheet.
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties or have you ever been treated for drug or alcohol abuse or have you used any illegal drug in the past year?  
 **Yes**    **No**      If YES, explain on a separate sheet.
6. Have you ever been convicted for an act committed in violation of any law or ordinance other than a minor traffic offense?  
 **Yes**    **No**      If YES, give full details on a separate sheet.
7. Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association?  
 **Yes**    **No**      If YES, explain on a separate sheet.
8. Do you treat cancer or epilepsy?  
 **Yes**    **No**      If YES, explain on a separate sheet.
9. Do you ever charge or collect your fees per case, lump sum agreed on or paid in advance, or on contract with a patient for a preagreed sum?  
 **Yes**    **No**, I charge and collect only after services are rendered.      If yes, explain on separate sheet.
10. Have you (or has a collection agency on your behalf) ever filed suit to collect unpaid sums from patients?  
 **Yes**    **No**      If YES, explain on a separate sheet.
11. Do you ever use a collection agency to collect unpaid sums from patients?  
 **Yes**    **No**      If YES, is your collection agency authorized to file suit to collect?    **Yes**    **No**
12. Have you ever treated a person that had previously been a research subject in any research program in which you were involved?  
 **Yes**    **No**      If YES, explain on a separate sheet.
13. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?  
 **Yes**    **No**      If YES, explain on a separate sheet.
14. Do you prescribe or dispense any prescription drugs?  
 **Yes**    **No**      If YES, explain on a separate sheet.
15. Do you treat Medi-Cal or Medicaid patients?  
 **Yes**    **No**      If YES, what percentage of your practice is devoted to seeing Medi-Cal or Medicaid patients? \_\_\_\_\_%.
16. Do you use any technique or therapy that is not currently taught in the acupuncture schools and colleges?  
 **Yes**    **No**      If YES, please list.
17. Do you make a differential diagnosis?  
 **Yes**    **No**      If No, do you limit your responsibility to the treating of symptoms?    **Yes**    **No**
18. Are your needles approved by the Food and Drug Administration?  
 **Yes**    **No**

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19. Do you follow state guidelines for the sterilization of needles?  
 **Yes**    **No**    Not Applicable. I only use disposable needles.
20. Check one:  
 I use only disposable needles;    I use some (or all) reusable needles.
21. If you use disposable needles, do you use them for only one insertion on one patient during a single visit and then throw them away?  
 **Yes**    **No, but I will do so.**    NOT APPLICABLE, I never use disposable needles.
22. Do you always maintain the needle shaft in a sterile state prior to insertion? (For example after removing a disposable needle from packaging or removing a reusable needle from a sterile needle tray.)  
 **Yes**    **No**
23. Is your acupuncture license current?  
 **Yes**    **No**
24. Do you always require your patients to sign an informed consent prior to treatment?  
 **Yes**    **No**   If Yes, attach a copy of the form you use.
25. Do you always record the patient's account of his or her progress?  
 **Yes**    **No**    No, but I will do so now.
26. Do you always record objective findings?  
 **Yes**    **No**    No, but I will do so now.
27. Do you always record details of treatment procedures?  
 **Yes**    **No**    No, but I will do so now.
28. Check one box describing your type of practice and fill in applicable blanks. Use a separate sheet if necessary.  
 Sole Proprietorship  
 Acupuncture professional corporation. Do you want corporate coverage? (additional charges may apply)    **Yes**    **No**  
 Partner in an Acupuncture Partnership: (Name Partners) \_\_\_\_\_  
 Employee, associate, or independent contractor with: (Name employers) \_\_\_\_\_
29. Do you (or does your acupuncture corporation or acupuncture partnership) employ any acupuncturists or other health care practitioners?  
 **Yes**    **No**   If YES, for each employee, list name and type of practice (e.g. DC,MD,DO,DPM,CA,RN,PT).  
\_\_\_\_\_  
\_\_\_\_\_
30. Provide the names of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (including acupuncturists, medical doctors, doctors of osteopathy, doctors of chiropractic, podiatrists, nurses, anesthetists, physical therapists, student or graduate preceptees, etc): Include name and practice type (L.Ac., MD, DO, DC, DPM, RN, PT).  
\_\_\_\_\_  
\_\_\_\_\_
31. Are you licensed to practice any other health care professions?  
 **Yes**    **No**   If yes, please circle: MD DO DPM DC RN RPT Other \_\_\_\_\_  
If yes, name malpractice insurance company for other profession \_\_\_\_\_ Policy expires \_\_\_\_\_
32. Do you now have acupuncture professional liability insurance?  
 **Yes**    **No**  
If yes, name malpractice insurance company \_\_\_\_\_ Policy expires \_\_\_\_\_
33. What date would you like for your malpractice insurance with the American Acupuncture Council to be in effect? \_\_\_\_\_
34. Do you refer to other doctors?  
 **Yes**    **No**   If yes, please circle: MD Ortho Neuro GP DC RN RPT CA Other: \_\_\_\_\_

➤ **Please complete the following:**

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35. Approximate number of patients you see weekly: \_\_\_\_\_
36. How many hours per week do you spend in direct professional work with patients? \_\_\_\_\_
37. What is the average time you spend professionally with each patient on a first office visit? \_\_\_\_ Follow up visit? \_\_\_\_\_
38. Please list all honors, recognition, awards, or publications of a professional nature.  
\_\_\_\_\_
39. List all hospitals at which you have ever held staff membership or at which you completed a residency and describe briefly the extent and dates of your hospital privileges, and, if applicable, the circumstances under which such privileges were suspended or terminated.

| Name of Hospital | Address | City | State, Country | Dates |
|------------------|---------|------|----------------|-------|
|                  |         |      |                |       |

 None

40. Please list all current memberships in acupuncture related specialty boards, academies, or colleges and dates so certified.  
\_\_\_\_\_  None

41. List all acupuncture teaching appointments you have held.  
\_\_\_\_\_  None
- | Name of School | Address | City, State, Country | Dates |
|----------------|---------|----------------------|-------|
|                |         |                      |       |

42. State pre-acupuncture education. Use a separate sheet if necessary.
- | College or University | Address | City, State, Country |
|-----------------------|---------|----------------------|
|                       |         |                      |
- | Degree | Major | Year of Graduation |
|--------|-------|--------------------|
|        |       |                    |

➤ **Please sign in the four required 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:** 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 on future follow-up data sheets 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, societies, any hospitals I presently or previously held staff privileges with, insurance carriers, trusts, administrators, etc., in past and future underwriting and claims matters, State Board of Acupuncture Examiners, and credit agencies to: the American Acupuncture Council or its authorized representative / investigator. I further agree that the organization releasing or obtaining the information, its agents, servants and employees, 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 in such released information. I agree that a photocopy of this authorization will be as valid as the original.

4. Sign here: \_\_\_\_\_ Date: \_\_\_\_\_