AMERICAN ACUPUNCTURE COUNCIL

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: ❒Male ❒Female

Fax or Mail Completed App & Payment to:

BQ of New York
3050 Whitestone Expwy, Suite #202
Flushing, NY 11354

(718) 886-5525 888-549-4955 Fax

Payment Detail (See Coverage Options page for choices):

Installment Due: .....

Optional Arbitration Forms ($20 / pack) .....

Optional Additional Insured (10%) .....

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 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

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Membership Application

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

38. List pre-acupuncture college education: _____ College _____ Yr Graduated _____ Degree

➢ 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 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, for any underwriting or claim-related inquiry. 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:** _____

Notice & Arbitration Agreement Order Form

This is an important reminder that all participants in our Elite Program must have an approved Healthcare Provider-Patient Arbitration Agreement signed by every patient. Your policy will not cover any claim by a patient against you where you cannot provide a signed copy of the Healthcare Provider-Patient Arbitration Agreement signed by the patient.

State law requires certain warnings on the arbitration agreement to be in red and of a certain type size. The arbitration agreements sold by the American Acupuncture Council meet that requirement and those of your insurer. We urge you to use these forms for every patient. Do not use photocopies of our form, since they will not have the red type. Do not use a different form unless your insurer approved the form in advance.

If you have treated a patient before he or she signs an arbitration form, simply have the patient sign a form and initial the form on the proper line, stating they agree to arbitrate for previous visits.

We believe this reminder is necessary to save you from making the mistake of not using the forms and then having an uncovered claim. Please remember that the arbitration forms are for your protection. This malpractice insurance program is available at reasonable rates, to a great extent, because of the arbitration form requirement, which avoids costly litigation.

As an added service and convenience to its members, the American Acupuncture Council offers the proper forms. **You may order 100 forms at $20.00 per pack** (Shipping and handling included).

Doctor & clinic name: _____

Total number of packs you are requesting: _____

AMERICAN ACUPUNCTURE COUNCIL

Please fax to: 888-549-4955

Rate Sheet

1. **Name:** _____

2. **Check a box below** to indicate the type of individual plan you desire, then place the applicable installment amount on page 1 of your application. If you graduated during the last 3 years from an American Acupuncture Council Member College, you may be eligible for an additional discount. Please call 800-838-0383 to determine if you qualify.

$100,000 / $100,000	**Elite Program**		**Preferred Program**	
	Annual	Quarterly	Annual	Quarterly
Base Rate	☐ $453	☐ $120	☐ $525	☐ $139
1st Yr. Licensee	☐ $327	☐ $85	☐ $363	☐ $95
2nd Yr. Licensee	☐ $403	☐ $106	☐ $460	☐ $122

$500,000 / $500,000	**Elite Program**		**Preferred Program**	
	Annual	Quarterly	Annual	Quarterly
Base Rate	☐ $628	☐ $168	☐ $750	☐ $201
1st Yr. Licensee	☐ $414	☐ $109	☐ $475	☐ $126
2nd Yr. Licensee	☐ $543	☐ $144	☐ $640	☐ $171

$1,000,000 / $3,000,000	**Elite Program**		**Preferred Program**	
	Annual	Quarterly	Annual	Quarterly
Base Rate	☐ $745	☐ $200	☐ $900	☐ $243
1st Yr. Licensee	☐ $473	☐ $125	☐ $550	☐ $146
2nd Yr. Licensee	☐ $636	☐ $170	☐ $760	☐ $204

$1,000,000 / $3,000,000 MCP *Malpractice & Premises Liability Cover*	**Elite Program**		**Preferred Program**	
	Annual	Quarterly	Annual	Quarterly
Base Rate	☐ $870	☐ $234	☐ $1,025	☐ $277
1st Yr. Licensee	☐ $598	☐ $159	☐ $675	☐ $181
2nd Yr. Licensee	☐ $761	☐ $204	☐ $885	☐ $238

BQ of New York Tel;718-886-5525

3050 Whitestone Expressway #202, Flushing, NY 11354

Above rates include all premiums, applicable taxes and installment processing fees (if any), and the $200 non-refundable annual membership fees for the American Acupuncture Council. While your premium is submitted with this application, submission in no way implies or guarantees coverage. Lower rates for the Elite Program are available to those using an approved informed consent/arbitration agreement with all patients.

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