

# 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
Email	Office Phone	Cell Phone	Fax	
Acupuncture License Number(s)	State Issued	Date Issued	Acupuncture College and Location	Year Graduated

### Practice Information

- License: Is your acupuncture license current?  Yes  No  Pending (New Licensees)
- Do you hold other healthcare licenses (RN, LMT, DC, etc.)?  Yes  No If **Yes**, please list: \_\_\_\_\_
- Referrals: When a patient needs care or diagnosis outside your scope, do you refer them to other health providers?  Yes  No
- Record Keeping: Do you always carefully document: a) Your patient's comments to you about their condition; b) your observations and conclusions regarding their condition; and c) any treatments you provided or recommended?  Yes  No
- Informed Consent: Do you always require your patients to sign an informed consent prior to treatment?  Yes  No
- Clean Needle: Do you always follow clean needle technique protocols in your practice? (If **No**, attach explanation)  Yes  No
- Check any of the following techniques you use in your practice:  
 Acupuncture During Labor & Delivery  Acupuncture to Turn a Breech Baby or Induce Labor  Injection Therapy  
 Facial Acupuncture  Techniques Not Taught in Acupuncture Schools (List): \_\_\_\_\_
- Do you treat cancer, epilepsy, or acquired immune deficiency syndrome?  Yes  No If **Yes**, do you limit your care to complimentary care only, provided in coordination with the patient's medical doctor?  Yes  No (If **No**, attach explanation)

### General Background (If you answer **Yes** to any of the following, attach a detailed explanation including status, dates, and outcomes.)

- Claim History: Has any malpractice claim or allegation ever been asserted against you or your associates?  Yes  No
- Potential Claims: Are you aware of any event or indication suggesting a claim may be made against you or that your care might have been deficient or caused harm?  Yes  No
- License Issues: Has any agency or association ever investigated or taken any action against you or your license?  Yes  No
- Insurance: Have you ever had malpractice insurance denied, canceled, or accepted on special terms?  Yes  No
- Criminal History: Have you been charged with or convicted of violating any law other than a minor traffic offense?  Yes  No
- Compromised Care: Have you ever provided care to patients when your ability to perform your professional duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug?  Yes  No

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## Membership Application

### Coverage Information

1. Who provides your current malpractice policy? \_\_\_\_\_ Expires: \_\_\_\_\_
2. Your malpractice coverage, if approved, is effective the date the app is received. For a later date, specify date: \_\_\_\_\_
3. Do you need Retroactive Coverage  Yes  No If **Yes**, indicate your desired retroactive date (charges may apply): \_\_\_\_\_
4. If you practice using a Professional Corp or Partnership, **which you own**, list below to add it, free of charge, as an Additional Insured:  
\_\_\_\_\_
5. List below to add any other entity added as an Additional Insured (e.g. your Employer, Landlord, etc.). Cost is 5% per entity:  
\_\_\_\_\_  
\_\_\_\_\_

**DECLARATION & AUTHORIZATION:** I hereby apply for membership/coverage and declare that the above statements are true, and I have not misstated or suppressed any facts. I understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy. I understand that if coverage is granted, I shall have the duty to report in writing, as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits. I hereby authorize release of information to the American Acupuncture Council for any underwriting or claim-related inquiry, from any acupuncture professional association, licensing board or health care organization. I understand that there is no guarantee that coverage will be renewed.

**CLAIMS-MADE ONLY (Does not apply if your Claims Reporting Basis is Occurrence):** I understand that if a policy is issued, the policy is limited to claims made against the insured during the policy period arising out of the rendering of, or 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.

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_

### Payment Detail (See Coverage Options page for choices)

1. **Coverage Option Page** – Choose Limits, Type, Installment, etc.
2. **Installments:**  Annual  Quarterly \*  10-Pay \*  
\* Quarterly or 10-Pay requires Auto Pay via Credit Card or ACH.
3. **Amount Due** (See Coverage Options Page for Details)  
Base Coverage Amount Due \_\_\_\_\_
  - Optional: AcuProperty @ \$103.20 \_\_\_\_\_
  - Optional: AcuPremiere @ \$125 \_\_\_\_\_
  - Optional: Arb Packets @ \$25/packet \_\_\_\_\_
  - Other: \_\_\_\_\_Total Amount Due: \_\_\_\_\_

### Credit Card or ACH (Complete applicable section and sign)

#### Credit Card Payments:

Card Type:  Visa  MasterCard  American Express

Card #: \_\_\_\_\_

Expires: \_\_\_\_\_

#### ACH Payments from Bank Account:

Account Type:  Checking  Savings

Account #: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Routing #: \_\_\_\_\_

Branch City: \_\_\_\_\_

You are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing.

Signature: \_\_\_\_\_

**Submit Your App** Email: info@acupuncturecouncil.com  
Fax: 714-571-1863



**American Acupuncture Council**  
1100 W. Town & Country Road, Suite 1400  
Orange, CA 92868  
800-838-0383

# AMERICAN ACUPUNCTURE COUNCIL

## COVERAGE OPTIONS (Payment Detail Section #3)

AAC understands practitioners have different practice needs. For that reason we offer installment payment options, payment processing options, various limits of liability, various programs (claims made, occurrence, Preferred, Elite), enhanced coverages, and discounts. Below is more detail on our optional coverages.

### Elite or Preferred Program:

The American Acupuncture Council is the only malpractice program which takes a pro-active approach to limiting your exposure to nuisance claims. We provide you with the paperwork needed to ensure your patient files are protected from attorneys attempting to attack you on some legal technicality. By selecting our **Elite** program, you agree to utilize an Arbitration Agreement and Informed Consent form as a standard part of your intake paperwork. In exchange, we provide a **significant discount** on your premium. The **Preferred** program does not require the use of an Arbitration Agreement.

### Optional AcuProperty Plus (Business Personal Property Insurance):

Business property damage caused by direct sudden, physical destruction or damage, or theft of the named insureds tools of the trade for the purpose of practicing the Named Insured's profession. \$500 deductible. Offered through Lloyd's of London. The rate for coverage is \$103.20 for the first \$10,000 limit of liability. Higher limits of liability available upon request.

### Optional AcuPremiere:

The left column shows the standard coverages of the Acupuncture Plus policy. The right column shows the enhanced coverages offered through the Acupuncture Premiere program, for the noted additional rate.

Acupuncture Plus	Acupuncture Premiere (Additional \$125)
Professional Liability	Professional Liability
Premises Liability, all practice locations – Bodily Injury / Slip and Fall	Premises and General Liability, all practice locations – Bodily Injury / Slip and Fall, plus Property Liability to third parties (subject to \$50K Fire Liability Sublimit when applicable) and Personal Injury Liability (no Sublimit)
Products Liability \$10,000 Sublimit	Products Liability - \$20,000 Sublimit
Covered Proceedings - \$30,000 Sublimit	Covered Proceedings - \$50,000 Sublimit
<ul style="list-style-type: none"> <li>• Board Defense</li> </ul>	<ul style="list-style-type: none"> <li>• Board Defense</li> </ul>
<ul style="list-style-type: none"> <li>• Audit Defense</li> </ul>	<ul style="list-style-type: none"> <li>• Audit Defense</li> </ul>
<ul style="list-style-type: none"> <li>• Good Samaritan</li> </ul>	<ul style="list-style-type: none"> <li>• Good Samaritan</li> </ul>
<ul style="list-style-type: none"> <li>• HIPAA Defense</li> </ul>	<ul style="list-style-type: none"> <li>• HIPAA Defense</li> </ul>
<ul style="list-style-type: none"> <li>• Sexual Misconduct Defense</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual Misconduct Defense</li> </ul>
Cyber Liability - \$10,000 Sublimit	Cyber Liability - \$20,000 Sublimit

### Optional Arb Packets:

If you choose the Elite Program, you agree to utilize an Arbitration Agreement and Informed Consent form as a standard part of your intake paperwork. AAC sells these two-sided forms, 100 forms per pack, for \$25 per pack (free postage and handling). It is acceptable to make your own copies of the forms, however, a certain portion of the Arbitration form must be shown to the patient in red ink. Given the cost of ink, many practitioners find it less expensive to purchase the forms through AAC.

**ELITE ARBITRATION/INFORMED CONSENT AGREEMENT**

**ELITE ARBITRATION AND INFORMED CONSENT AGREEMENT**

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

I understand that I am insured under the provisions of the Elite Malpractice Policy. As a requirement of the Elite policy pricing, I must maintain signed copies of **arbitration/Informed Consent agreements** for every patient treated during my policy period in my office files. I will use **only the approved red lettered arbitration and informed consent** to treat form. I will have every current patient sign forms as they come in to see me for care to cover any treatments rendered after my policy activation date.

I understand and agree that having a signed arbitration and informed consent form is a requirement for coverage of any future claim that may arise.

I also understand that I can pay an additional premium at any time (change to "Preferred" policy) and no longer be required to have the arbitration and informed consent forms signed. If I do so, it will only apply to care that is after the date the insurance company accepts my request to transfer out of the Elite Program.

I have read and agree to the above.

**Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_