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

1. License: Is your acupuncture license current? ❐Yes ❐No ❐Pending (New Licensees)
2. Do you hold other healthcare licenses (RN, LMT, DC, etc.)? ❐Yes ❐No If ***Yes***, please list:________________________________
3. Referrals: When a patient needs care or diagnosis outside your scope, do you refer them to other health providers? ❐Yes ❐No
4. 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
5. Informed Consent: Do you always require your patients to sign an informed consent prior to treatment? ❐Yes ❐No
6. Clean Needle: Do you always follow clean needle technique protocols in your practice? (If ***No***, attach explanation) ❐Yes ❐No
7. Check any of the following techniques you use in your practice:
   - ❐ Acupuncture During Labor ❐ Acupuncture to Turn a Breech Baby or Induce Labor ❐ Injection Therapy
   - ❐ Facial Acupuncture ❐ Techniques Not Taught in Acupuncture Schools (List): ____________________________________
8. 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.)

1. Claim History: Has any malpractice claim or allegation ever been asserted against you or your associates? ❐Yes ❐No
2. 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
3. License Issues: Has any agency or association ever investigated or taken any action against you or your license? ❐Yes ❐No
4. Insurance: Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ❐Yes ❐No
5. Criminal History: Have you been charged with or convicted of violating any law other than a minor traffic offense? ❐Yes ❐No
6. 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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AMERICAN ACUPUNCTURE COUNCIL

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. If you need retroactive coverage, indicate your desired retroactive date. Additional 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 represent that the name signed/typed below was signed/typed by the Applicant, and the Applicant agrees to be fully bound by every answer in this Application. 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: __________

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

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: ______________________

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
• Board Defense	• Board Defense
• Audit Defense	• Audit Defense
• Good Samaritan	• Good Samaritan
• HIPAA Defense	• HIPAA Defense
• Sexual Misconduct Defense	• Sexual Misconduct Defense
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.

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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:** ______________________

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