AMERICAN ACUPUNCTURE COUNCIL

ASH Provider 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:

American Acupuncture Council
1100 W. Town & Country Road, Suite 1400
Orange, CA 92868

800-838-0383 714-571-1863 (FAX)

Payment Detail (See Coverage Options page for choices):

Installment Due: ----------

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

Optional Additional Insured (5%) ----------

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: _____

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Professional Information *(Attach Additional Sheets When Needed)*

1. Is your acupuncture license current? ❒Yes ❒No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *Yes*, attach explanation) ❒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 <u>one insertion only</u>, then <u>throw them away</u>? ❒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 <u>always</u> 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 <u>always</u> record the patient's account of his or her progress? ❒Yes ❒No ❒No, but I will do so now.
19. Do you <u>always</u> record objective findings? ❒Yes ❒No ❒No, but I will do so now.
20. Do you <u>always</u> 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 (5% cost), or separate limit (20% cost). Add sheets as needed:

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

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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

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 I have not misstated or suppressed any facts. I agree and 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.

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:** _____

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ASH Provider 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.

$1,000,000 / $3,000,000 MCP ***Includes one year of free premises liability***	**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

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.