



# AMMA

The American Manual Medicine Association

## ACUPUNCTURE MEMBER APPLICATION

### 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
<input type="checkbox"/> Practitioner (Students provide expected date / hrs for graduation)	Acupuncture School	Graduation Date	Hours Completed
<input type="checkbox"/> Student			
Acupuncture License Number(s)	State Issued	Date Issued	Social Security Number Birth Date Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

### PROFESSIONAL INFORMATION (STUDENTS SKIP TO QUESTION 9)

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 are you aware of any circumstance that could give rise to such a claim? (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 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.



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## PROFESSIONAL INFORMATION (CONTINUED FROM PAGE 1)

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. On what date would you like your new coverage to take effect? (*Must be on or after the date your application is received*): \_\_\_\_\_
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. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):  
 \_\_\_\_\_
34. List any entity (*such as your P.C.*) you want as an additional insured (*cost is 10%/entity, 20% max*): \_\_\_\_\_
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 |
|---------|--------------|--------|
| _____   | _____        | _____  |

### MEMBERSHIP OPTIONS AND PAYMENT

Professional & Student Membership includes \$1 million / \$3 million Professional & Premises Liability Coverage. Fellowship & Affiliate categories do not include coverage. Check the following box  if you do not want \$10 of your Membership to go to the AMMA Pac.

- |  |              |   |       |
|--|--------------|---|-------|
| <input type="checkbox"/> Professional - See Rate Sheet |              |   |       |
| <input type="checkbox"/> Student                       | @ \$290      | = | _____ |
| <input type="checkbox"/> Fellowship                    | @ \$100      | = | _____ |
| <input type="checkbox"/> Association Affiliate         | @ \$50       | = | _____ |
| <input type="checkbox"/> Additional Insured            | @ 10%/Entity | = | _____ |
| <input type="checkbox"/> Arbitration Forms             | @ \$20/Pack  | = | _____ |
- TOTAL AMOUNT DUE:** \_\_\_\_\_

- Check  MasterCard  Visa  Discover  AMEX
- Card #: \_\_\_\_\_ Expires: \_\_\_\_\_

### SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for membership and / or coverage. I declare that the above statements are true and I have not suppressed or misstated any facts. I agree that this declaration shall be a basis for, and form a part of, my professional liability policy and my AMMA membership. I understand untrue statements could void my policy and / or my AMMA membership. I understand that, I have a 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. I understand that Returned checks will be charged a \$35.00 administrative fee.

SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

REMIT TO: **AHS** (American Health Source)  
 2040 RAYBROOK SE, SUITE 103 GRAND RAPIDS MI 49546  
 888-375-7245 - PHONE 616-575-9066 - FAX

**RATE SHEET – PROFESSIONAL MEMBERSHIP**  
**\$1,000,000 / \$3,000,000 PROFESSIONAL & PREMISES LIABILITY COVERAGE**

**ELITE DISCOUNT PROGRAM**

Under the Elite Program, Members agree to follow a Risk Management protocol with patients. Members use an Arbitration Agreement and Informed Consent form when enrolling each of their patients in care, reducing the costs of malpractice disputes. Members receive substantially discounted coverage rates, as listed below, when using the Elite Program risk management system.

<b>CLAIMS MADE</b>	<b>ANNUAL</b>	<b>QUARTERLY</b>
Established Practitioner	<input type="checkbox"/> \$970	<input type="checkbox"/> \$259
Discounted Rate – 1 <sup>st</sup> Year in Practice	<input type="checkbox"/> \$698	<input type="checkbox"/> \$184
Discounted Rate – 2 <sup>nd</sup> Year in Practice	<input type="checkbox"/> \$861	<input type="checkbox"/> \$229
<b>OCCURRENCES</b>		
Established Practitioner	<input type="checkbox"/> \$1,035	<input type="checkbox"/> \$277
Discounted Rate – 1 <sup>st</sup> Year in Practice	<input type="checkbox"/> \$731	<input type="checkbox"/> \$193
Discounted Rate – 2 <sup>nd</sup> Year in Practice	<input type="checkbox"/> \$913	<input type="checkbox"/> \$244

**STANDARD PREFERRED PROGRAM**

Members enrolled in the Preferred Program are not required to follow the Elite Program Risk Management protocol. Standard rates, as listed below, apply to Members in the Preferred Program.

<b>CLAIMS MADE</b>	<b>ANNUAL</b>	<b>QUARTERLY</b>
Established Practitioner	<input type="checkbox"/> \$1,125	<input type="checkbox"/> \$302
Discounted Rate – 1 <sup>st</sup> Year in Practice	<input type="checkbox"/> \$775	<input type="checkbox"/> \$206
Discounted Rate – 2 <sup>nd</sup> Year in Practice	<input type="checkbox"/> \$985	<input type="checkbox"/> \$263
<b>OCCURRENCES</b>		
Established Practitioner	<input type="checkbox"/> \$1,209	<input type="checkbox"/> \$325
Discounted Rate – 1 <sup>st</sup> Year in Practice	<input type="checkbox"/> \$817	<input type="checkbox"/> \$217
Discounted Rate – 2 <sup>nd</sup> Year in Practice	<input type="checkbox"/> \$1,052	<input type="checkbox"/> \$282