

# Invitation to Membership



TENNESSEE CHIROPRACTIC ASSOCIATION

## Membership Investment Categories:

Gold	\$1,500
Regular	\$750
Non-Resident	\$100
Student	\$100
Retiree	\$100

New Licensee Levels	
1 <sup>st</sup> Year	\$100
2 <sup>nd</sup> Year	\$300
3 <sup>rd</sup> Year	\$500
4 <sup>th</sup> Year	Regular Dues

*Gold Membership investments may be paid annually, semi-annually, quarterly, or monthly. Regular Membership investments may be paid annually, semi-annually, or quarterly. 1st Year New Licensee membership investments may be paid annually or semi-annually. Non-Resident, Student, and Retiree membership investments may be paid annually. All may be paid automatically on this basis by credit card.*

### Please Print or Type

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Office Manager or Contact Person: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Website: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

College Attended: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

TN License # \_\_\_\_\_ Date License Issued: \_\_\_\_\_

Additional State Licenses: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_ Medicare # \_\_\_\_\_

Preferred method of delivery of the *Doctor Privilege*:  fax  email

Type of Practice:  Solo  Partnership  Multiple  MD/DC  Other

Please List Other DC's Practicing in Your Office: \_\_\_\_\_

Please check all of the techniques commonly used in your office:

- |   |                                      |                                       |                                |
|---|--------------------------------------|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Palmer               | <input type="checkbox"/> SOT         | <input type="checkbox"/> DNFT         | <input type="checkbox"/> A.K.  |
| <input type="checkbox"/> Diversified          | <input type="checkbox"/> Nimmo       | <input type="checkbox"/> Activator    | <input type="checkbox"/> Drop  |
| <input type="checkbox"/> Toggle               | <input type="checkbox"/> Cox         | <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> HIO   |
| <input type="checkbox"/> Thompson             | <input type="checkbox"/> CBP         | <input type="checkbox"/> Meridian     | <input type="checkbox"/> Other |
| <input type="checkbox"/> Meric                | <input type="checkbox"/> Pierce      | <input type="checkbox"/> Craniosacral | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blair Upper Cervical | <input type="checkbox"/> Kinesiology | <input type="checkbox"/> Gonstead     | <input type="checkbox"/> Other |

Does your office have or utilize any of the following? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Electronic Billing | <input type="checkbox"/> Certified Therapy Assistants |
| <input type="checkbox"/> X-Ray Machine      | <input type="checkbox"/> Certified X-Ray Technicians  |
| <input type="checkbox"/> Handicap Access    | <input type="checkbox"/> Licensed Massage Therapists  |
| <input type="checkbox"/> MD on staff        |   |

Physical Therapy?

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Ultrasound              | <input type="checkbox"/> Hydrotherapy | <input type="checkbox"/> Therapeutic Massage |
| <input type="checkbox"/> Intersegmental Traction | <input type="checkbox"/> Russian Stim | <input type="checkbox"/> Exercise Rehab      |
| <input type="checkbox"/> Hydrocollator           | <input type="checkbox"/> EMS          | <input type="checkbox"/> Interferential      |

Does the office market any of these products on-site?(Please specify on attached sheet.)

- |  |   |
|--|---|
| <input type="checkbox"/> Braces or Splints       | <input type="checkbox"/> Orthopedic Pillows |
| <input type="checkbox"/> Vitamins or Supplements | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Orthotics               | <input type="checkbox"/> Other _____        |

Please answer the following questions: (circle your answer)  
if YES, please include explanation on separate sheet.

- |     |    |  |
|-----|----|--|
| Yes | No | 1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?   |
| Yes | No | 2. Have you ever been convicted of a felony?   |
| Yes | No | 3. Have you ever been suspended from the Medicare or Medicaid program or has your participation status ever been modified?   |
| Yes | No | 4. Has your malpractice insurance ever been cancelled, suspended, restricted, or special-rated?  |
| Yes | No | 5. Has your license to practice chiropractic in any state been suspended, restricted, revoked, voluntarily surrendered, been subject to a consent order or has probation ever been invoked?  |
| Yes | No | 6. Within the last 5 years, have you been removed as a provider for an HMO, PPO, etc.?   |
| Yes | No | 7. Have you ever received sanctions from a regulatory agency or state board?   |
| Yes | No | 8. Has any information on you ever been reported to the National Practitioner Data Bank?   |
| Yes | No | 9. Are you currently engaged in the illegal use of drugs?  |
| Yes | No | 10. Within the last 5 years, have you been reprimanded by any professional board or review committee for conduct related to the use of alcohol or any drug?  |
| Yes | No | 11. Do you or a member of your family own, have investment in, or otherwise have a business interest in any clinical laboratory, diagnostic center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health service, equipment, or supplies? |

If so, please provide the following:

Name of Organization: \_\_\_\_\_ Type of Organization: \_\_\_\_\_  
Nature of Business Interest (owner, partner, investor, etc): \_\_\_\_\_

*I hereby apply for membership in the Tennessee Chiropractic Association, agreeing to abide by the By-Laws, rules, regulations, and code of ethics and any amendments hereafter adopted by the Tennessee Chiropractic Association Board of Directors and the Association membership. I also hereby certify that the information that I have provided on this application is truthful and complete to the best of my knowledge.*

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Communications Consent**

I understand that by providing my mailing address, e-mail address, telephone number and fax numbers, I consent to receive communications sent by or on behalf of the Tennessee Chiropractic Association (and its subsidiaries and affiliates, including its Societies and District organizations) via regular mail, e-mail, telephone, or fax.

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

**Payment Information**

**TENNESSEE CHIROPRACTIC ASSOCIATION**

Membership Investment Categories:

<b>Gold</b>	<input type="checkbox"/> \$1,500	<b>New Licensee</b>	
<b>Regular</b>	<input type="checkbox"/> \$750	<input type="checkbox"/> 1st Year	<b>\$100</b>
<b>Non-Resident</b>	<input type="checkbox"/> \$100	<input type="checkbox"/> 2nd Year	<b>\$300</b>
<b>Student</b>	<input type="checkbox"/> \$100	<input type="checkbox"/> 3rd Year	<b>\$500</b>
<b>Retiree</b>	<input type="checkbox"/> \$100		

*Dues are based a calendar year schedule.*

**Please Select a Payment Schedule:**

<b><u>Gold</u></b>	<b><u>Regular</u></b>	<b><u>Non-Resident</u></b>	<b><u>Student</u></b>	<b><u>Retiree</u></b>	<b><u>1st year</u></b>
<input type="checkbox"/> Annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Annually
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Quarterly				<input type="checkbox"/> Semi-Annually
<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Semi-Annually				
<input type="checkbox"/> Monthly	<input type="checkbox"/> Monthly <i>(bank draft or credit card debit only)</i>				

**Please Select a Payment Method:**

- Check payable to TCA
- Auto Debit -- If you choose this option, please fill out the attached form.
- Credit Card Debit -- If you choose this option, please fill out the attached form.

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

MasterCard or Visa  
Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

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

*7% of Regular and Gold Member Dues go to the TCA PAC fund to support legislative efforts in Tennessee*

Please mail or fax your application to:  
**Tennessee Chiropractic Association**  
628 West Iris Drive ▪ Nashville, TN 37204  
(615) 383-6231 ▪ Fax (615) 383-6233

# Credit Card Preauthorization Form

I hereby authorize the Tennessee Chiropractic Association (TCA) to debit my credit card for the purpose of paying my monthly, quarterly or semi-annual association fees and/or donations to the TCA.

This authority is to remain in full force and effect until I notify the TCA that I wish to end this agreement and the TCA has had reasonable time to act on it; or until the TCA has sent me 10 days written notice that they will end this agreement.

It is my duty to notify the TCA 10 days prior to a scheduled debit of any changes made to my designated credit card account.

I attest I am an authorized owner of the credit card account listed below, and am exercising my powers as such.

Total Amount to be debited \$ \_\_\_\_\_  Monthly  Quarterly  Semi Annually

Credit Card # \_\_\_\_\_ Exp date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

# AutoPay Bank Draft Plan

Tennessee Chiropractic Association is pleased to offer members a convenient automatic bank draft program to pay monthly association dues. Your monthly association payment is automatically paid by your bank every month.

## How the Program Works

- **Absolutely Free** -There is no cost to sign up for the program, and it will save you the cost of postage stamps.
- **No More Invoices** -You won't have to worry about your payment being mailed. Your bank statement will reflect your payment was made.
- **Your Payment is on Time** -The AutoPay Bank Draft Program will provide you with assurance your monthly payment is made on time. You won't have to wonder "Did I pay my Association Dues this month?"
- **Convenience In Making your Payment** -You do not have to take the time to make out a check and mail the payment each month.
- **Easy Reconciliation** - Your bank statement will show the amount of your payment made to the TCA monthly.
- **Simple Enrollment** - Simply sign the attached preauthorization form and include a voided check of the bank account to be drafted each month.

## How You Enroll

1. Complete and Sign the Information and Preauthorization Form.
2. Enclose a **Voided Check** of the Bank Account to be drafted.
3. Please provide us notice of any changes at least 10 days prior to a scheduled draft.
4. Your payment will automatically be drafted as long as you are a member of the TCA. Remember to notify the TCA of any changes at least 10 days prior to a scheduled bank draft. If you change bank accounts, simply send us a new voided check. **\*\*IF YOU WISH TO DISCONTINUE IN THE PROGRAM, SIMPLY NOTIFY THE TCA TO DELETE YOU FROM THE AUTOPAY BANK DRAFT PROGRAM**

## AutoPay Bank Draft Program Enrollment Form

Please mark your records. You have been set up to have your monthly association fees drafted from your bank account on the 15<sup>th</sup> of each month. Please send this completed form and a voided check to TCA to be set up. We must receive your form by the 5th of the month in order to start drafting your account for that month.

Monthly Amount to be drafted: \$ \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

## Preauthorization Form

I (we) hereby authorize the Tennessee Chiropractic Association (TCA) and Automated Payment Systems, Inc. (APS) acting on behalf of the TCA to initiate credit or debit entries to such account by funds transfer and/or automated clearing house ("ACH") transfer or (b) to initiate any and all necessary reversing entries and/or adjustments for any entries made in error for the purpose of paying my monthly association fees to the TCA.

This authority is to remain in full force and effect until I notify the TCA that I wish to end this agreement and the TCA has had reasonable time to act on it; or until the TCA or my bank has sent me 10 days written notice that they will end this agreement. I understand that in the event my account has insufficient funds to cover the monthly payment amount drafted, or my draft rejects due to bank account changes or any other reason, a \$25.00 reject fee will be assessed and due. It is my duty to notify the TCA 10 days prior to a scheduled bank draft of any changes made to my designated account, including but not limited to closed status, bank ownership changes and account changes.

I attest I am an authorized owner of the Depository account listed below, and am exercising my powers as such.

Bank ABA # \_\_\_\_\_ Account #: \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**ATTACH A VOIDED CHECK**