Invitation to Membership

TENNESSEE CHIROPRACTIC ASSOCIATION

Membership Investment Categories:

Gold	**$1,500**	**New Licensee**	
Regular	**$750**	**1st Year**	**$375**
Non-Resident	**$100**		
Student	**$100**		
Retiree	**$100**		

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 ☐mail

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:

☐Palmer	**☐SOT**	**☐DNFT**	**☐A.K.**
☐Diversified	**☐Nimmo**	**☐Activator**	**☐Drop**
☐Toggle	**☐Cox**	**☐Acupuncture**	**☐HIO**
☐Thompson	**☐CBP**	**☐Meridian**	**☐Other**
☐Meric	**☐Pierce**	**☐Crainosacral**	**☐Other**
☐Blair Upper Cervical	**☐Kinesiology**	**☐Gonstead**	**☐Other**

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

☐ **Electronic Billing**
☐**X-Ray Machine**
☐**Handicap Access**
☐**MD on staff**
☐**Certified Therapy Assistants**
☐**Certified X-Ray Technicians**
☐**Licensed Massage Therapists**

Physical Therapy?

☐**Ultrasound**
☐**Intersegmental Traction**
☐**Hydrocollator**
☐**Hydrotherapy**
☐**Russian Stim**
☐**EMS**
☐**Therapeutic Massage**
☐**Exercise Rehab**
☐**Interferential**

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

☐**Braces or Splints**
☐**Vitamins or Supplements**
☐**Orthotics**
☐**Orthopedic Pillows**
☐**Other**_____
☐**Other**_____

Please answer the following questions: (circle your answer)
if YES, please include explaination 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:

Gold	**☐$1,500**	**New Licensee**	
Regular	**☐$750**	**☐1st Year**	**$375**
Non-Resident	**☐$100**		
Student	**☐$100**		
Retiree	**☐$100**		

Dues are based a calendar year schedule.

Please Select a Payment Schedule:

Gold	**Regular**	**Non-Resident**	**Student**	**Retiree**	**1st year**
☐ Annually	☐ Annually	☐ Annually	☐ Annually	☐ Annually	☐ Annually
☐ Quarterly	☐ Quarterly				☐ Semi-Annually
☐ Semi-Annually	☐ Semi-Annually				

Please Select a Payment Method:

☐ Check payable to TCA

☐ Auto Debit -- If you choose this option, please fill out the attached form.

Signature:_____Date:_____

☐ MasterCard or Visa
Card #_____ Exp. Date_____

Signature:_____Date:_____

_____Please initial here if you would like us to charge your credit card automatically according to the schedule you have selected.

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

Introducing the AutoPay Bank Draft Plan

A Convenient Method of Paying Your Monthly Association Dues

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 Trips to the Post Office** You won't have to worry about your payment being mailed. Your bank statement will reflect your payment was made.
- **Your Payment is Made 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 each month.
- **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 15th 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: _____

Tennessee Chiropractic Association, 628 West Iris Drive, Nashville, TN 37204

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