

# Invitation to Membership



Tennessee  
Chiropractic  
Association

## Membership Investment Categories:

<b>Gold</b>	<b>\$1,500</b>
<b>Regular</b>	<b>\$750</b>
<b>Non-Resident</b>	<b>\$100</b>
<b>Student</b>	<b>\$50</b>
<b>Retiree</b>	<b>\$100</b>

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, quarterly or monthly. 1st Year New Licensee, Non-Resident, Student, and Retiree membership investments may be paid annually. Second and third year New Licensee membership investments may be paid annually or semi-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 #:** \_\_\_\_\_

**Type of Practice:**    Solo    Partnership    Multiple    MD/DC    Other

**Please List Other DCs 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"/> Acupuncture |
| <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.)

- 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 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?<br>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"/> \$50	<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, Student or Retiree</u></b>	<b><u>1st year</u></b>	<b><u>2<sup>nd</sup> and 3rd 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"/> 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, please see form on next page)</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.
- MasterCard or Visa

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Billing Address \_\_\_\_\_ Zip \_\_\_\_\_

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**  
 2123 8<sup>th</sup> Avenue, South ▪ Nashville, TN 37204  
 (615) 383-6231 ▪ Fax (615) 383-6233

# TCA Membership: An Investment in your Future!

## TCA Membership benefits include:

- Discounts on seminars
- Assistance on insurance inquiries
- TCA Journal subscription
- Free classified ads
- Important updates via *Doctor Privilege*
- Valuable resources on Members Only website
- 24/7 referrals by 'Find a Doctor' on TNChiro.com
- Advocacy and legislative alerts
- And the list is growing!



## Upgrade to TCA GOLD Membership and receive these valuable benefits:

- All regular member benefits **PLUS**
- Free 12 hour seminar
- 2 Free CAT memberships for staff
- Special Recognition at TCA events
- Increased support for chiropractic

## Make Life Easier . . . Enroll in the TCA Automatic Payment Program!

It's easy! Sign up now for the TCA Automatic Payment Program. You can pay your membership and contributions in easy installments from your credit card or checking account. Please complete the form below and return it to the TCA. We must receive your form by the 5th of the month in order to start charging your account for that month. Drafts are processed the 15th of each month.

### Preauthorization Form

I/We hereby authorize the Tennessee Chiropractic Association (TCA) to initiate credit or debit entries to my account listed below, or 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. It is my duty to notify the TCA 10 days prior to a scheduled payment of any changes made to my account, including but not limited to closed status, bank ownership changes and account changes.

Doctor's Name \_\_\_\_\_

Date Authorized \_\_\_\_\_

Amount to be drafted: \$ \_\_\_\_\_ for  TCA Dues  
 \$ \_\_\_\_\_ for  Eagle Pledge  
 \$ \_\_\_\_\_ for  Lobbyist Pledge

\$ \_\_\_\_\_ for  TCA PAC Pledge  
 (PAC will be in a separate draft)

TOTAL DRAFT \$ \_\_\_\_\_

Draft my account on the following payment schedule:  Monthly  Quarterly  Semi-Annually

Questions regarding membership benefits, payment plans or support contributions? Call the TCA at (615) 383-6231.

**Please draft my bank account as listed below.**

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 \_\_\_\_\_

Name on Account \_\_\_\_\_

**ATTACH A VOIDED CHECK**

**Please draft my credit card account as listed below.**

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

Name on card \_\_\_\_\_

Card # \_\_\_\_\_ Exp Date \_\_\_\_\_

Billing address of card \_\_\_\_\_

Zip \_\_\_\_\_

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

### EAGLE Society



The Eagle Society is a \$1000 annual contribution which goes towards the advancement of chiropractic. Recent endeavors include funding for statewide pro-chiropractic public awareness campaigns and member resources.

### TCA PAC



Your contribution to the TCA PAC goes directly to current and future legislators who support the chiropractic profession. Contributions to the TCA PAC are not tax deductible.

### TCA Lobbyist Fund

This fund offsets the cost for TCA Lobbyists, Alexanderia Honeycutt and John Williams, who work with TCA E.D., Tiffany Stevens to promote and protect chiropractic interests on the Hill. Donations to this fund are not tax deductible.