

**BOARD OF REGISTRATION IN MEDICINE
COMMITTEE ON ACUPUNCTURE
200 HARVARD MILL SQUARE SUITE 330
WAKEFIELD, MASSACHUSETTS 01880**

ACUPUNCTURE COMPLAINT FORM

PLEASE TYPE OR PRINT CLEARLY AND PROVIDE ALL THE REQUESTED INFORMATION ON THE FOUR (4) PAGES OF THIS FORM.

<input type="checkbox"/> Mrs.	<u>Your First Name</u>	<u>Last Name</u>	<u>Patient (if different)</u>
<input type="checkbox"/> Ms.			
<input type="checkbox"/> Mr.			
Mailing Address: _____			
City: _____		State: _____	Zip: _____
Business/Daytime Phone: (_____) _____		Home Phone: (_____) _____	

**PLEASE LIST THE FULL NAME AND ADDRESS OF THE ACUPUNCTURIST
(PLEASE CHECK SPELLING FOR ACCURACY)**

Acupuncturist's Last Name: _____	First Name: _____
Acupuncturist's Address: _____	
Acupuncturist's City: _____	State: _____ Zip: _____
Acupuncturist's License Number: _____	
Acupuncturist's Business Phone: (_____) _____	

Nature of Complaint

(Please mark as many items as necessary)

- | | |
|---|--|
| <input type="checkbox"/> Substandard Acupuncture Care | <input type="checkbox"/> Professional Misconduct |
| <input type="checkbox"/> Sexual Misconduct | <input type="checkbox"/> Rude or Discourteous Behavior |
| <input type="checkbox"/> Impaired by Alcohol or Drugs | <input type="checkbox"/> Impaired by Mental or Emotional Illness |
| <input type="checkbox"/> Failure to Provide Acupuncture Records | <input type="checkbox"/> Overcharge for Acupuncture Records |
| <input type="checkbox"/> Drug Dealing | <input type="checkbox"/> Criminal Conviction |
| <input type="checkbox"/> Patient Neglect/Abandonment | <input type="checkbox"/> Unlawful Discrimination |
| <input type="checkbox"/> Billing for Services Not Rendered | <input type="checkbox"/> Failure to Supervise Staff |
| <input type="checkbox"/> False Advertising | <input type="checkbox"/> Fraud |

Other: _____

Failure to complete and sign this Release may prevent investigation of your complaint

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1. If you are not the patient, what is your relationship to the patient?
 Spouse Parent Child Other Relative
 Friend Attorney Other _____
2. Has this acupuncturist provided treatment in the past? (Do not count the treatment in this complaint)
 Yes No
3. Is this acupuncturist the person you (or the patient) usually see when you seek treatment?
 Yes No
4. How long have you (or the patient) been under this acupuncturist's care?
 1 to 30 days 1 to 12 months 1 to 2 years 2 to 4 years
 4 to 8 years 8 years or more
5. What form of payment was made? Check as many as apply
 Commercial Insurance Health Maintenance Organization Medicaid
 Medicare Campus Worker's Compensation
 Self Other
6. Are you (patient) expected to pay a portion of this bill of pocket?
 Yes No
7. Has the acupuncturist adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
 Yes No
8. Is the fee or copayment in dispute?
 Yes No
9. Has the acupuncturist been contacted about this complaint?
 Yes No

The information in this complaint is true, correct and complete to the best of my knowledge.

YOUR SIGNATURE: _____ DATE: ____/____/____

MAIL THIS FORM TO: Board of Registration in Medicine
Consumer Protection Coordinator
 200 Harvard Mill Square Suite 330
 Wakefield, Massachusetts 01880