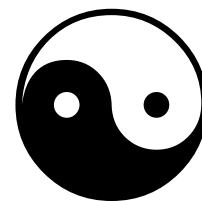


Commonwealth of Massachusetts
Board of Registration in Medicine
Committee on Acupuncture

560 Harrison Avenue – G4
Boston, MA 02118



(617) 654-9869
FAX (617) 357-8453

**THE ACUPUNCTURE COMPLAINT PROCESS
A CONSUMER'S GUIDE**

Filing a Complaint

Attached is the Acupuncture Complaint form that you requested. This form must be filled out completely and clearly and the medical release(s) on Page 2 of the form must be signed. **The form must be returned to the Consumer Protection Unit at the Board of Registration in Medicine (Board).**

What Happens Next

Board staff will review your complaint along with the acupuncturist's history.

If the complaint is opened, you will be informed that the acupuncturist has been asked to respond to complaint. Typically, a response to the allegations from the acupuncturist is obtained within six (6) weeks. After the acupuncturist's response is received, your complaint and the acupuncturist's response are assessed together.

The Complaint Subcommittee, a subcommittee of the Committee on Acupuncture (COA), which includes three

(3) acupuncturists and one public member, considers cases brought before it by Board staff. The Complaint Subcommittee can recommend a range of dispositions for a complaint from dismissal to a variety of disciplinary actions. The full COA must approve a recommendation for disciplinary action.

After Closure, Then What?

The complaint and the acupuncturist's response become part of the acupuncturist's permanent file, accessible to you, either after the case is dismissed or after the acupuncturist has been formally charged. If the case is dismissed, you can receive a copy of response and dismissal letter for a nominal fee. If the case goes to a hearing, all of the records introduced into evidence are available to you. (The patient name and other identifiers are removed to protect the patient's privacy.)

You cannot appeal the decision to dismiss your case. Please keep in mind that the decision to dismiss indicates

only that further investigation is not likely to result in discipline and therefore is not the best use of resources. It is not a comment on the reality, pain, or frustration of your experience.

Important Addresses

A copy of the COA regulations (243 CMR 4.00 and 243 CMR 5.00) can be found in law libraries and in some town libraries. You also may purchase them by contacting the State Book Store, State House, Room 116, Boston, MA 02133.

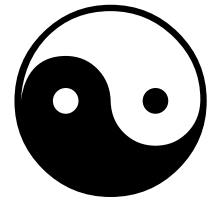
Remember:

Be an informed health care consumer. The Acupuncture Unit of the Board of Registration in Medicine is a valuable source of information. Use this information to learn about your acupuncturist, and always ask questions when you need clarification.

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

<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr.	<u>Your First Name</u>	<u>Last Name</u>	<u>Patient (if different)</u>
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

RELEASE OF ACUPUNCTURE RECORDS AND INFORMATION

Name of Patient: _____ Date of Birth: ____ / ____ / ____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS, ACUPUNCTURISTS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL AND OR ACUPUNCTURE RECORDS TO, AND DISCUSS MY MEDICAL AND OR ACUPUNCTURE CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: _____
(or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATION, DIAGNOSES OR TREATMENT WITH AND OR RELEASE ANY AND ALL OF MY MEDICAL AND ACUPUNCTURE RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. C.233 §20B.

Signature of Patient: _____ Date: _____
(or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

1. If you are not the patient, what is your relationship to the patient?

<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Other Relative
<input type="checkbox"/> Friend	<input type="checkbox"/> Attorney	<input type="checkbox"/> 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?

<input type="checkbox"/> 1 to 30 days	<input type="checkbox"/> 1 to 12 months	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 2 to 4 years
<input type="checkbox"/> 4 to 8 years	<input type="checkbox"/> 8 years or more		

5. What form of payment was made? Check as many as apply

<input type="checkbox"/> Commercial Insurance	<input type="checkbox"/> Health Maintenance Organization	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare	<input type="checkbox"/> Campus	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Self	<input type="checkbox"/> 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
 560 Harrison Avenue – G4
 Boston, MA 02118