

userconference '09

Presented by CollaborateMD & Medical Association of Billers (MAB)

Event Registration and Credit Card Authorization Form

Event Registration

Attendee Type: Customer Prospective Customer MAB Member Partner/Affiliate Other

Full Name: _____

Email: _____

Company: _____

Title: _____

Phone: _____

Fax: _____

Company Address: _____

of Attendees: _____ Names of additional attendees: _____

Accommodations

A special discount has been negotiated at the Rosen Centre Hotel for Conference '09 attendees. Space is limited, and availability is on a first-come, first-served basis. To book your discounted room, please contact the hotel directly:

2008 Rosen Centre Hotel | 9840 International Drive, Orlando, Florida 32819

(407) 996-9840 | Toll Free (800) 204-7234 | Fax (407) 996-0865

Terms & Conditions

All registrations must be received by 5/11/09. All cancellations must be received in writing. Those cancellations received by March 15, 2009 are 100% refundable. Those received after March 15, 2009 will receive a refund minus a \$100 administrative fee; those received after March 31, 2009 are non-refundable; however, if you are unable to attend UC09, you may transfer your registration to another person without penalty if requested in writing by 5/11/09. Please send an email to Accounting@CollaborateMD.com with the new attendee's name and contact information. If CollaborateMD cancels the event for any reason, all registration fees will be refunded to the attendees by check within 20 calendar days of cancellation of the event.

201 E. Pine St. | Suite 1310 | Orlando, Florida 32801



Payment

Your credit card will be charged upon completion of this form, acceptance of our terms and conditions, and submission of this form to our office via fax.

I, _____, hereby authorize CollaborateMD to charge the following card for UC09 registration:

Contact Phone: _____ Date: _____

Please indicate your payment below:

| Your # of Attendees | Super Early Bird Pricing for Members Only* (February) | Early Bird Pricing for Members Only* (March) | Regular & Non-Member Pricing (4/1/09 - 5/11/09) | Your Sub-total |
|---------------------|---|--|---|----------------|
| Single Attendee | \$400 | \$599.00 | \$899.00 | |
| Each Add'l Attendee | \$350 | \$549.00 | \$849.00 | |
| Promo Code | | | | |
| Total | | | | |

*"Members Only" pricing applies to CollaborateMD customers and Medical Association of Billers (MAB) members

Please charge my credit card this one time dollar amount (as listed above as "Total"): _____

I have read and accept the "Terms & Conditions" (found on page 1).

Card Type: Visa MasterCard American Express Discover

Name on the Card: _____

Card#: _____

Exp Date: ____ / ____ (mm/yy) CCID: _____

Card Holder Signature: _____

Please return this form via fax to
(407) 641-9062

201 E. Pine St. | Suite 1310 | Orlando, Florida 32801

