ICD-10CM WORKSHOP REGISTRATION FORM

Student Information - Please Clearly Print Date:

TODAY'S DATE:_____ WORKSHOP DATE(S):_____

The following information is used for billing and identification only and will not be sold or used for any solicitation. Your information is secured by HIPAA privacy policies.

STUDENT CONSENTS

I give permission to publish my name, phone number and email address on the class roster?

YES ☐ NO ☐

Email address: _____

Your information will not be sold or used by any other source, or used for solicitation. Your email may be used to contact you concerning school or classroom correspondence only.

How did you hear about Chronicles Billing Inc?

☐ Online ☐ Henry County Times ☐ Henry Neighbor ☐ Friend ☐ Other

_____

Student Name:

_____

First Last MI

Address:

_____

Street Apt # City State Zip

Date of Birth: ____/____/_____

Contact Info:

Home (____) _____ **Cell** (____) _____ **Wk**(___)_____

Name and phone number of a person in case of an emergency:

_____

Optional – The following questions could be helpful in case of an emergency

Are there any health related illnesses we should be made aware of? ÿ **No** ÿ **Yes**
If yes, what?

_____

ICD-10CM 2-DAY WORKSHOP REGISTRATION FORM CAN BE FAXED TO
(678) 298-4741
- OR -
MAILED TO:
Chronicles Billing Inc.
C/O Genieve Nottage, MBA, BSHA, CPMA, CPC-I, CPC-H, CPC, CMRS

----------**PAYMENT INFORMATION**----------

Payment Options: ***(Cash or Money Order can be mailed or dropped-off 2 weeks prior to the event)***

Cash ☐

Money Order ☐ **#**_____ **(No personal checks accepted)**

Credit Card ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

FULL NAME ON CARD: _____

CREDIT CARD #: _____

CREDIT CARD ADDRESS: _____

EXPIRATION DATE: _____

SECURITY CODE: _____

EMAIL ADDRESS: _____

I _____ authorize a **onetime** only charge to my credit card in the amount of **$399.99** as payment of the Chronicles Billing, Inc. 2-Day ICD-10 Workshop.

_____ _____
Initials Date