



Medical Billing Course

April 10-11, 2009

IDEC Seminars Registration Form

Name of attendees: _____

Title: _____

Address: _____

City: _____ State _____ Zip _____

Ph: _____ Fax: _____ Cell: _____

E-mail: _____

COURSE TUITION
\$995/per Doctor
\$695/per Staff member

METHOD OF PAYMENT: VISA MASTER CARD CHECK US \$

NAME ON CREDIT CARD: _____

CREDIT CARD # _____ EXP. DATE: _____

TOTAL TUITION AMOUNT\$ _____

SIGNATURE: _____

By signing I'm authorizing my credit card to be charged the total tuition amount stated above.

Mail registration form with payment to:

International Dental Education Continuum, Inc.
8740 N. Kendall Drive Suite 215
Miami, FL 33176

Or fax to: 1-800-634-0525

If you have any questions, please contact me at 305-763-3421 or e-mail me at Claudia@idecseminars.com. Make sure you visit our website www.idecseminars.com for upcoming courses.

Refunds or cancellations MUST be made in writing and received at the IDEC office no later than 30 days prior to the start of registered course. A \$200 administrative fee will be deducted from all refunds.