

Welcome to the
So California Chapter of AMBA



Name: _____ AMBA member# _____
Company Name: _____ Date of Birth (MM/DD) _____
Address _____ City, St & Zip _____
Home Phone: _____ Cell Phone _____
Email: _____ Web: _____

Are you new to Medical Billing? YES / NO If NO- how many years experience? _____

Do you own a Medical Billing Company _____ If YES, how long have you been in
business? _____

Do you have any clients yet? YES / NO

What specialty billing are you experienced in? _____

What specialty would you like to learn about? _____

NSF checks – you will be charged \$25.00 for each NSF check.

Please include this enrollment form with the \$35.00 yearly enrollment fee to the address above.

Rules of the Chapter:

1. You are obligated to vote in 75% of all polls posted in the groups area
2. You are obligated to join the yahoo groups area
3. You are obligated to vote in all officer elections
4. You must be a National AMBA member and keep your membership current through your So California Chapter of -AMBA membership
5. Must attend at least 3 meetings per year. Penalties include non-renewal of membership.

You MUST be a member of AMBA (American Medical Billing Assoc) to participate in the Local Chapter. We will verify your AMBA membership when you join or renew your Chapter membership. You are required to maintain your AMBA membership to participate in the Local Chapter. Please refer to Chapter Hand book for details.

Dues: \$35.00 a year (other fees may apply for Seminars/Training/Special Events etc).

Make checks payable to:

So California Chapter of AMBA
PO Box 7744
Laguna Niguel, CA 92607
Ph (949) 887-6022
FAX (888) 256-7636

Member's Signature Date

Officer's Signature Payment Received CK CC CA Date



AMBA Registration Form

Please print and send with your payment to AMBA.

Business Name: _____

Name: _____

Address: _____ Birthday(MM/DD) _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax _____

___ I paid online (*Please fax, mail or email this registration form to AMBA for our records.*)

___ Individual Membership **\$99**

___ Business Membership (*You may include up to 3 separate members*) **\$199**

___ Add **\$79** for Each Additional Business Member Over 3

___ **\$59** Student Membership Attached is proof

Order Total:\$ _____

=====

Payment Method: ___ Credit Card ___ Check ___ Money Order ___ Cashiers Check

Credit Card: ___ Visa ___ Master Card ___ Discover ___ American Express

Credit Card #: _____

Credit Card Expiration: MM _____ YY _____

Name On Credit Card (*Please print clearly*): _____

Signature: _____ Date: _____

=====

Business Members (ONLY) Names:

Member #1: _____ Email: _____

Member #2: _____ Email: _____

Member #3: _____ Email: _____

Member #4: _____ Email: _____

Send Membership Application and Payment to:

American Medical Billing Association
4297 Forrest Drive
Sulphur, OK 73086

Or, fax your application with credit card payment to (580) 622-5809.