

April 10–13, 2011 ✨ Orlando, FL ✨ The Walt Disney World Swan and Dolphin Resort

Name: _____
(please type or print)

Sharing your demographic information with HCCA will help us create better networking opportunities for you. Please fill out the following information.

STEP 1: Demographic information

What is your functional job title? Please select one.

- | | |
|--|--|
| <input type="checkbox"/> Academic/Professor | <input type="checkbox"/> Consultant |
| <input type="checkbox"/> Administration | <input type="checkbox"/> Controller |
| <input type="checkbox"/> Asst Compliance Officer | <input type="checkbox"/> Ethics Officer |
| <input type="checkbox"/> Attorney (In-House Counsel) | <input type="checkbox"/> Executive Director |
| <input type="checkbox"/> Attorney (Outside Counsel) | <input type="checkbox"/> General Counsel |
| <input type="checkbox"/> Audit Analyst | <input type="checkbox"/> HIM Professional |
| <input type="checkbox"/> Audit Manager/Officer | <input type="checkbox"/> HIPAA/Privacy Officer |
| <input type="checkbox"/> Billing Manager/Officer | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Charger Master | <input type="checkbox"/> Medical Director |
| <input type="checkbox"/> Chief Compliance Officer | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> CEO/President | <input type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Patient Safety Officer |
| <input type="checkbox"/> Chief Information Officer | <input type="checkbox"/> Pharmacy Director |
| <input type="checkbox"/> Chief Medical Officer | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Quality Assurance/
Quality of Care |
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Regulatory Officer |
| <input type="checkbox"/> Coder | <input type="checkbox"/> Reimbursement Coordinator |
| <input type="checkbox"/> Compliance Analyst | <input type="checkbox"/> Research Analyst |
| <input type="checkbox"/> Compliance Coordinator | <input type="checkbox"/> Risk Manager |
| <input type="checkbox"/> Compliance Director | <input type="checkbox"/> Trainer/Educator |
| <input type="checkbox"/> Compliance Fraud Examiner | <input type="checkbox"/> Vice President |
| <input type="checkbox"/> Compliance Officer | <input type="checkbox"/> Other (please list below) |
| <input type="checkbox"/> Compliance Specialist | |

List others not listed here:

Please tell us if you are a first-time attendee of the Compliance Institute:

- This is my first annual Compliance Institute

What is your primary health care entity?

- | | |
|---|--|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Long-Term Care |
| <input type="checkbox"/> Ambulance/Transportation | <input type="checkbox"/> Managed Care |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Medical Device Manufacturer |
| <input type="checkbox"/> Consulting Firm | <input type="checkbox"/> Medical/Clinical Research |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Government Provider | <input type="checkbox"/> Other Provider of Services/
Products to Health Care Entities |
| <input type="checkbox"/> Health System | <input type="checkbox"/> Payor/Insurance |
| <input type="checkbox"/> Health System/Teaching | <input type="checkbox"/> Pharmaceutical Manufacturer |
| <input type="checkbox"/> Home Care/Hospice | <input type="checkbox"/> Physician Practice |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Hospital/Teaching | <input type="checkbox"/> Retail Pharmacy |
| <input type="checkbox"/> Integrated Delivery System | <input type="checkbox"/> Third-Party Billing |
| <input type="checkbox"/> Integrated Health System | <input type="checkbox"/> Other (please list below) |
| <input type="checkbox"/> Laboratory | |
| <input type="checkbox"/> Law Firm | |

List others not listed here:

What certifications do you hold? Select all that apply.

- | | | | |
|--------------------------------|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> BA | <input type="checkbox"/> CHC | <input type="checkbox"/> FHFMA | <input type="checkbox"/> MSHA |
| <input type="checkbox"/> BBA | <input type="checkbox"/> CHE | <input type="checkbox"/> JD | <input type="checkbox"/> MSN |
| <input type="checkbox"/> BS | <input type="checkbox"/> CHP | <input type="checkbox"/> LLM | <input type="checkbox"/> MT |
| <input type="checkbox"/> BSN | <input type="checkbox"/> CIA | <input type="checkbox"/> MA | <input type="checkbox"/> NHA |
| <input type="checkbox"/> CCEP | <input type="checkbox"/> CPA | <input type="checkbox"/> MBA | <input type="checkbox"/> PhD |
| <input type="checkbox"/> CEM | <input type="checkbox"/> CPC | <input type="checkbox"/> MHA | <input type="checkbox"/> RHIA |
| <input type="checkbox"/> CCS | <input type="checkbox"/> CPHQ | <input type="checkbox"/> MPA | <input type="checkbox"/> RHIT |
| <input type="checkbox"/> CCS-P | <input type="checkbox"/> DDS | <input type="checkbox"/> MPH | <input type="checkbox"/> RN |
| <input type="checkbox"/> CFE | <input type="checkbox"/> ESQ | <input type="checkbox"/> MS | |

List others not listed here:

**REGISTRATION CONTINUES
ON NEXT PAGE (OVER)**

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STEP 2: Please type or print your contact information

Mr. Mrs. Ms. Dr.

Member ID _____

First MI Last

Credentials _____

Title _____

Place of Employment _____

Mailing Address _____

City State Zip

Phone _____

Fax _____

E-mail (required for confirmation notification) _____

REGISTRATION PAYMENT TERMS Checks are payable to HCCA. Credit cards accepted: American Express, Diners Club, MasterCard, or Visa. HCCA will charge your credit card the correct amount should your total be miscalculated.

TAX DEDUCTIBILITY All expenses incurred to maintain or improve skills in your profession may be tax deductible; including tuition, travel, lodging and meals. Please consult your tax advisor (Federal tax ID # 23-2882664).

CANCELLATIONS/SUBSTITUTIONS No refunds will be given for no-shows or cancellations. You may send a substitute or receive a conference credit. If you have questions, please call HCCA at 888-580-8373. Additional charges may apply. Cancellation by telephone is NOT valid. Please fax written cancellations to 952-988-0146 or e-mail helpteam@hcca-info.org.

GROUP DISCOUNTS \$100 per person for five or more from the same company, based on membership status; only if each attendee completes a registration and they are faxed or mailed in simultaneously.

CONFERENCE BINDERS Attendees will not automatically receive conference binders, but will receive electronic access to course materials. If you would like to purchase the binders for \$75, check "Conference Binders" on your registration form. (Please note: Monday/Tuesday conference sessions require two 3-inch D-ring binders, plus a third binder if you also register for the pre- and/or post-conferences.)

STEP 3: Choose your options

PRICES LISTED REFLECT SAVINGS

REGISTER on or before 1/6/11 on or before 3/31/11 on or after 4/1/11

- HCCA Members.....\$999.....\$1,049.....\$1,099
- Membership Renewal & Registration.....\$1,294.....\$1,344.....\$1,394
- Non-Members.....\$1,149.....\$1,199.....\$1,249
- New Membership & Registration*.....\$1,199.....\$1,249.....\$1,299
- Pre-Conference Registration Morning.....FREE.....\$175.....\$175
- Pre-Conference Registration Afternoon.....FREE.....\$175.....\$175
- Post-Conference Registration.....FREE.....\$175.....\$175
- Conference Binders†.....\$75.....\$75.....\$75
- Discount for 5 or more from the same company.....(\$100).....(\$100).....(\$100)

*New members only. (Dues regularly \$295 annually.)
†Binders may be purchased by registered conference attendees only.

TOTAL:

STEP 4: Payment

- Check enclosed (payable to HCCA)
- Invoice me Purchase Order # _____
- I authorize HCCA to charge my credit card (choose card below):
 American Express Diners Club MasterCard Visa

Credit Card Account Number _____

Credit Card Expiration Date _____

Cardholder's Name _____

Cardholder's Signature _____

CI0411

HOW TO REGISTER

MAIL Include registration form with check payable to:
HCCA, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435

ONLINE Visit www.compliance-institute.org

FAX to 952-988-0146 (including billing information)

QUESTIONS? Call 888-580-8373 or e-mail helpteam@hcca-info.org

**HCCA
COMPLIANCE
INSTITUTE**



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www.compliance-institute.org