MDHBA
A Healthcare Receivables Management Association

Membership Application

1. Membership Type

(Please refer to the MDHBA membership flyer or web site for complete membership definitions.)

- ❒ **Agency Member, Category I** - $650.00 1-5 employees
- ❒ **Agency Member, Category II** - $750.00 6-15 employees
- ❒ **Agency Member, Category III** - $875.00 16-30 employees
- ❒ **Agency Member, Category IV** - $1,025.00 30+ employees
- ❒ **Associate Member** - $350.00
- ❒ **Vendor Member**- $350.00

**Company must have Active Member Agency status to apply for this category.*

Agency/Company Name_____

Healthcare Trade Name (if different)_____

Primary Member Contact Name _____ Title _____

2. General Information

Address _____

City_____State _____ Zip _____

Phone _____Fax_____

E-Mail _____Web_____

Recommended/Referred By _____

Date business was organized/incorporated _____

Sections 3-6 to be completed by Agency Member applicants ONLY.

3. Operations

Total No. of Employees_____ Is your office bonded? ❒ Yes ❒ No

Software used_____Type of Insurance Carried _____

What is the closest Metropolitan Area to your office? _____

List other associations in which your company holds membership_____

_____

4. Client Information

No. of physicians served _____ No. of dentists served _____ No. of hospitals served _____

What services are offered by your company (check all that apply):

- ❒ Collections
- ❒ Credit Reporting
- ❒ Accounts Receivable Management
- ❒ Early Out
- ❒ Practice Management
- ❒ Other

5. Results

Healthcare collections:

Gross listings last fiscal year $_____

Gross collections last fiscal year $_____

Accounts receivable management or early out:

Gross billings last year $_____

Professional Management:

No. of clients _____

Percent of business that is healthcare related _____%

6. References

Please list three healthcare client references.

1. Company Name _____Contact Name_____

Address _____

City_____State _____ Zip _____

Phone _____

2. Company Name _____Contact Name_____

Address _____

City_____State _____ Zip _____

Phone _____

3. Company Name _____Contact Name_____

Address _____

City_____State _____ Zip _____

Phone _____

7. Associate Applicants Only

In the space below, please briefly describe your interest in the healthcare ARM industry and provide the name of an MDHBA Agency Member with which you or your organization does business.

_____

_____

_____

8. Vendor Applicants Only

Please provide a brief, 50 words or less description about your company and its products/services.

_____

_____

_____

_____

9. Payment

If you are paying by check, please make check payable to MDHBA and return your application and payment to: MDHBA, 218 Glorieta Dr., St. Augustine, FL 32095. Membership is based on the calendar year and dues are prorated after your initial 12 months of membership to bring you current through December of your second membership year.

If you would like to pay by credit card, please complete the information below and mail this application, or fax it to 630.359.4274.

Credit Card: ❒ AMEX ❒ MC ❒ VISA Amount: $_____

Card Number: _____

Exp. Date: _____ Billing Zip Code:_____

Sec. Code:_____Name on Card: _____

For office use only
Accepted on: _____ By: _____
Payment Received ___ Yes ___ No
Payment Type ___ Check ___Credit Card

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I certify that the above information is true and correct. I understand that my application for membership will be reviewed by the MDHBA Board and that, upon approval, my payment will be processed. If membership is not approved, my payment will be returned to my attention.

Name_____Date_____

Please call 630.359.4273, or e-mail info@mdhba.org if you have any questions. Thank you.

Membership dues and/or other contributions to MDHBA are not tax deductible as charitable contributions. However, they may be tax deductible as ordinary and necessary business expenses.

We acknowledge that the information we provide on this application may be used by MDHBA for publishing an online and/or printed directory, e-mail or fax communications to and from the membership.