

Registration Information

Registration Form for: _____

Please fill in the information below and mail or fax it with your check or your credit card information to reserve your spot. The price for this course is \$ _____. Payment must accompany registration. Space is limited.

Name: _____

Name of Practice: _____

Home Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____

Work Phone: _____

Fax: _____

Email Address _____

Method of Payment: Check _____ Credit Card _____

Credit Card: ___ MasterCard ___ Visa ___ Discover

Name as it appears on the card and billing address if different from above:

Card Number: _____ Security Code _____

Expiration Date:(mm/yy) _____

Billing Address(if different from above) _____

REFUNDS(minus 15%) are given after the course date, if the cancellation request is received 14 days before the course date. No refunds are granted after that date. If the course is cancelled by Therapy Concepts, a full refund will be given. Any Questions? Call 720-974-4700 or 800-667-9020. Fax: 720-493-1191

Please make your checks payable and mail to:

Therapy Concepts
7340 S. Alton Way, #11-D
Englewood, CO 80112