

PAYMENT SERVICE REQUEST/AUTHORIZATION

PROGRAM (mark those that apply):

- ☐ Dance Classes/Gymnastics
☐ Studio All Star Dance Team
☐ Twisters Gymnastics Team
☐ All-Star Cheer



Name of Child(ren) _____

Parent's Name _____

Payment Date:

___ 1st of Month

PAYMENT TYPE:

☐ Checking ☐ Savings ☐ Credit Card ☐ Debit Card

Last 4 digits of account/card: _____

Name of Financial Institution _____

Name on Account (if different) _____

Billing Address (if different) _____

Contact Phone (if different) _____

I (We) authorize and request the Gateway Region YMCA to charge my (our) Checking/savings or credit/debit card account for monthly program fees. I (We) further authorize the financial institution to process these fees. Charges are continuous as long as the program is in session. Allow a minimum of two weeks for your account to be established. Please check your statements regularly. Should any draft not be honored by my financial institution, for any reason, I (we) realize that I am (we are) still responsible for that payment plus a \$25 service charge applied by the YMCA for each return. This is in addition to any service fee the financial institution may make. The YMCA will resubmit the draft for payment automatically and will notify me with any issues. If you notice a discrepancy in your bank or credit cards account, notify us promptly. Refunds are not issued for discrepancies over 90 days.

Authorized Signature (must be 18) _____ Date _____

Joint Signature, if applicable _____ Date _____

(Initial) _____ I understand the Y needs 30 days written notice of intent to Discontinue automatic payments.

Office Use Only - Unit ID: _____ Staff Initials: _____

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