Credit Card and/or Recurring Payment Authorization Form

Please complete the information below:

I _____ authorize Strong Family Health Center to charge my credit card (indicated below); $_____ on or after the 5th each month for payment of my fitness center membership, these payment will continue until I request that they end in writing, **or** charge a one time payment of $_____.

(If different than above.)
Name of Primary Fitness Member: _____

Phone: _____

Email (for receipts):_____

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name
(as it appears on card) _____

Billing Address _____

_____

Account Number _____

Exp. Date _____ CCV _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify SFHC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that SFHC may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.