Registration

Program________________ Today's Date________/________/________

Name(print)____ Social Security Number______________________

Address____City_________________________State_________Zip____________

Date Of Birth_______/_______/_______ Phone # (H)(_______)_____________________ (C)(_______)______________________

Email____School________________________________

Parent Email____

Emergency Contact____Relationship_______________________

Home #(______)________________________Cell #(______)________________________Work #(______)______________________

How Did You Hear About Our Program____ Referred By________________________

PAYMENT METHOD

☐ ***Electronic Fund Transfer (EFT) or Credit Card Payment***

By checking this box and signing this form you are authorizing the Sanford Health POWER Center to withdraw your program fee(s) along with any other incurred POWER Center fees from either your checking or savings account or designated credit card on the 15th of the month and at the end of the month depending on the program. The withdrawal will be ongoing until you inform the Sanford Health POWER Center in writing of your desire to discontinue. To discontinue, you MUST sign a Discontinuation Form five (5) days prior to the withdrawal date of your next month's fees. If you fail to notify the Sanford Health POWER Center five (5) days prior to your next withdrawal date, you will be responsible for the fees of the upcoming month. Please mark an X in the box below to indicate which account you would like your fees withdrawn. Please note that all non-sufficient funds or closed accounts will be charged a $20 service fee. **Please print clearly.**

***Please initial and date after reading ______________________________ Staff _______________________________**

☐ Checking ☐ Savings Name of Bank____

Address____

Account #____

Route #____

☐ Credit Card_______________________#____Exp.____________

Name as it appears on the credit card:____

YOUR WITHDRAWAL DATE WILL BE: (*office use only*) __________________________________

☐ ***Pre-Payment***

I choose to pre-pay for services rendered at the Sanford Health POWER Center. Upon completion of pre-paid services, it is my responsibility to pre-pay prior to *further services at the Sanford Health POWER Center or choose the Electronic Fund Transfer or Credit Card payment method.* I understand that all pre-paid programs must be completed within a six (6) month time period unless special arrangements have been made with the POWER Staff. All remaining sessions will be forfeited. I understand that pre-paid services are NON-REFUNDABLE.

***Please initial and date after reading _________________/_______/_______ Staff _________________/_______/_______**

____
Signature Parent/Guardian Signature Date

____
Staff Signature Date