Registration

Today's Date________/________/________

Name(print)____ Gender______________________

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

☐ ***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 your designated credit card on the 2nd of the month. The withdrawal will be ongoing until you inform the Sanford Health POWER Center in writing of your desire to discontinue. 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 Please mark an X in the box below to indicate which account you would like your fees withdrawn.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.**

☐ Credit Card____________________#____Exp.____________

Name as it appears on the credit card:____

☐ ***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.

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Signature | Parent/Guardian Signature | Date

____

Staff Signature | Date

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