

GYMNASTICS CENTER OF CHATTANOOGA
Competitive Team Program
Automatic Payment Options

RESPONSIBLE PARTY _____

CHILD'S NAME _____

TUITION PAYMENT _____

ADDITIONAL AMOUNT TOWARD COMPETITION FEES _____

BEGINNING DATE _____

SIGNATURE _____

Please choose one of the following options for your autopay:

The 1st of the month ☐

OR the 15th of the month ☐

☐ **Choice 1: Autodraft from checking account**

ATTACH VOIDED CHECK IF POSSIBLE

Name on Account: _____

Bank Name: _____

Bank Routing Number: _____

Checking Account Number: _____

☐ **Choice 2: Automatic charge to credit/debit card**

Name on Card: _____

Credit Card Number: _____

Exp Date: _____ Zip Code: _____