



Pre-authorized Payment (Debit) Service Authorization Agreement

I (we) authorize LEGACY GYMNASTICS and the financial institution listed below to electronically debit my (our) Checking Savings Account specified below:

_____		_____
Bank Name		Branch Location
_____		_____
City	State	Zip Code
_____		_____
BankTransit/ABA Number		Account Number

This authority is to remain in full force and effect until Legacy has received written notification from me of its termination in such time and in such manner as to afford Legacy a reasonable opportunity to act on it. By signing below I agree and understand that A) I must give a 30 day notice to stop monthly withdrawals and B) that a 30 day notice must be given by the tenth of current month in order not to be charged for the next month. If notice is given past the 10th of the month then the full payment will be expected for the next month unless other arrangements have been made.

_____	_____
Name (Please Print)	Phone Number
_____	_____
Signature	Date

**** Please attach a VOIDED check to form and place in payment box.**