

CROSSFIT LPF

PLEASE PRINT (except where applicable):

MEMBERSHIP NAME: _____
TELEPHONE NUMBER: _____
EMAIL ADDRESS: _____

MAILING ADDRESS: _____
FAX NUMBER: _____
CITY: _____ STATE: _____ ZIP CODE: _____

FACEBOOK NAME: _____
INSTAGRAM NAME: _____

HOW ARE YOU PAYING? (please check one):
CHECKING: _____ SAVINGS: _____
VISA: _____ MC: _____ DISCOVER: _____ AMEX: _____

CREDIT CARD INFORMATION:
CC ACCOUNT NUMBER: _____ EXP DATE: _____

NOTE: IF YOU ARE PAYING BY CHECK, PLEASE ATTACH A
VOIDED CHECK TO THIS PAYMENT FORM OR PROVIDE
THE FOLLOWING:

BANK ACCOUNT INFORMATION:
BANK NAME: _____
TELEPHONE NUMBER: _____
CITY: _____ STATE: _____ ZIP CODE: _____

ROUTING # (9 digits): _____ ACCOUNT NUMBER: _____
NOTE: Routing numbers starting with 5 are invalid!

PAYMENT INSTRUCTIONS: (please circle one):
3 MONTH SPECIAL: \$297 (NEW Member ONLY) MONTHLY: \$135 6 MONTH SPECIAL: \$690
START DATE: _____ / _____ / _____ PAYMENT AMOUNT: _____

PAYER'S SIGNATURE: _____ DATE: _____
PAYER'S NAME (if different than above): _____

I hereby authorize **CROSSFIT LPF**, hereinafter called Company, to initiate debit entries to my bank account. This authorization to remain in full force until Company has received written notification from me of its request for termination in such time and in such manner as to afford Company a reasonable opportunity to act on it (30 days notice). I understand that this payment plan may be cancelled by Company at any time. I represent and warrant that I am authorized to execute this Authorization Agreement and I indemnify and the Company, bank and their agents harmless from damage, loss, or claim resulting from all authorizations actions hereunder. **Initial:** _____