REGIONAL THERAPY CENTER
A SERVICE OF SARATOGA HOSPITAL

Health & Fitness Gym
6 Care Lane
Saratoga Springs, NY 12866
518-583-8383

Automatic Payment Request and Authorization

- ❑ **Credit Card**

Credit Card Type: **VISA** **MC** **AEX** **DIS**	Credit Card #:
Exp. Date:	3-digit Verification Code (on back of card):

Name as it appears on card: _____

I agree to have my credit card charged $40.00 (Forty Dollars) by Saratoga Hospital on the 25th of the month for the monthly membership fee as I have chosen.

I further understand that the monthly payment is due **regardless** of the frequency that I use the facility.

Member Signature Date

Witness Date

- ❑ **Electronic Fund Transfer (EFT)**

Type of account: ___Checking Account ___Savings Account	
Routing #	Account #:

I agree to have the account indicated above charged $40.00 (Forty Dollars) by Saratoga Hospital on the 25th of the month for the monthly membership fee as I have chosen.

I further understand that the monthly payment is due **regardless** of the frequency that I use the facility.

Member Signature Date

Witness Date