

# Longwood Medical Area Child Care Center

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## Authorization Agreement for Direct Debit

I (we) authorize the Longwood Medical Child Care Center, Inc. (hereafter "LMACCC") to initiate debit entries to my (our) checking account at the depository indicated below. Such debits will be limited to monthly tuition charges and late pickup fees calculated according to the terms of my (our) contract with LMACCC. This authorization is limited to a maximum monthly debit of \$\_\_\_\_\_ or **invoiced amount**  (please check).

Parent's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Customer ID or Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Begin Debit**

**Change Information**

**Cancel**

\_\_\_\_\_  
(MONTH/YR)

**Attach a voided check or complete the information below:**

Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

This authorization is to remain in full force and effect until LMACCC and my (our) bank have received written notice from me of its termination in such a manner as to afford LMACCC and the bank a reasonable opportunity to act on it.

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_