Executive Function High School "Jump Start" Workshop Registration

Saturday August 10th, 2019 12:00-3:00pm

Facilitator: Elizabeth Morarie, B.A., Gifted/2e Specialist

Investment: $150 – must be paid in full by July 31

Student 1 Full Name: _____

DOB: _____ Grade for 2019-2020 School Year: 9th 10th 11th 12th

School for 2019-2020 Year: _____

Student 1 email address: _____

Student 2 Full Name: _____

DOB: _____ Grade for 2019-2020 School Year: 9th 10th 11th 12th

School for 2019-2020 Year: _____

Student 2 email address: _____

Parent Name(s): _____

Address: _____

City: _____ ZIP: _____ Phone: _____

Parent Email(s): _____

Parent Phone: (H) _____ (C) _____ (W) _____

Emergency Contact Name: _____ Phone:_____

Please Initial Your Acknowledgement of the Following:

_____ Parent understands that a deposit of $50 is required to hold a student's spot in the Executive Function Boot Camp. Deposit is Non-Refundable.

_____ Balance must be paid in full by July 31, or your student may lose his/her spot to someone on the wait list. No refunds will be made after this date.

Signature of Parent_____ Date: _____

Please return this form with payment via email (registration@peakgifted2e.com)

fax (720) 356-0172, or mail: PEAK Exceptional Services,

Attn: Terri Lucero, P.O. Box 53, Eastlake, CO 80614-0053

Integrative Health Solutions, PLLC d/b/a PEAK Exceptional Services
Credit Card Billing Authorization Form

If you would like to enjoy the convenience of using a credit card for payment of the Executive Function High School Workshop, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. *Note that charge will be listed under **Integrative Health Solutions** on your receipt and statement. **No refunds will be made after July 31, 2019. **$50 deposit is non-refundable** and will be deducted from refund if payment was made in full.

Customer Information:

Parent Name: _____ Phone: _____
Student Name(s): _____

Payment Information
I authorize Integrative Health Solutions, PLLC to bill the card listed below as specified (Check one)
____ Amount: $150.00/per student - Payment in FULL for High School Workshop.
____ Amount: $50/per student - for Deposit (Now), $100/student Balance to be processed on 7/31/19
____ Amount: $100.00/per student – Balance due for HS Workshop.

Credit Card Information
Integrative Health Solutions, PLLC accepts most major credit cards.

Credit card type: _____
Credit card number: _____
Expires: _____ /_____

Cardholder's name: _____
(as shown on credit card)

Cardholder's Zip Code (required) _____
(from credit card billing address)

Cardholder's Billing Address: _____
(Street Address)

_____
(City/State)

Security Code Number (CVV) On Card: _____

Cell Phone (Text) or Email Address for Receipts: _____

Authorized Cardholder Signature: _____

Date: _____