

Membership Cancellation Notice

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Member Name & Address (Below)

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Provider Name & Address (Below)

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Dear Provider:

I need to cancel my membership to our office. I would like to cancel my membership 30 days from the date below my signature. I do not want to defer my membership which I understand is an option.

I understand that accumulated units of care and / or office visits are not refundable at any time during the course of my membership or upon termination of the membership. All accumulated units of care and / or office visits expire upon termination of this agreement and cannot be used beyond the termination date by Client or household member.

I understand that if I have multiple memberships to different Provider offices, and wish to cancel those memberships, that I must make a request for cancellation to each Provider office. I understand that only a written letter from your office is sufficient notice that my membership has been actually cancelled.

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

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