

Direct Primary Care Membership Cancellation Form

Membership to be Cancelled		
Last Name:		First Name: Middle Initial:
Date of Birth:	Sex: ☐ Male ☐ Female	Phone: ()
Home address:		
Email address:		
If additional memberships need to be cancelled, please use the back of this form.		
Cancellation Date		
Membership is cancelled effective on the date that Collier Family Medical, PLLC receives this signed form or a later date that you specify.		
Date I want my membership to end:		
Cancellation Policy		
Direct Primary Care Agreements with recurring dues may be cancelled at any time and for any reason. You can cancel your membership by providing written notice to us at 1220 N. Flint St. Lincolnton, NC 28092 or through our website. We recommend that you mail the cancellation notice by certified mail and keep a record for your files. Or you may deliver the notice directly to the clinic manager at your membership clinic. (The days and times for in clinic cancellations are subject to change depending upon the availability of the clinic manager.) If you deliver the notice in person, please be sure to get a receipt for your records. A cancellation postmarked at least 5 business days prior to your next billing date should result in no further recurring billing. If less than 5 business days, you may be billed one more time. To ensure that we have accurate information about the account being closed, we recommend you print and use the online form. During the 12 month period after the patient signs this Direct Primary Care agreement, we may terminate the direct primary care agreement for one of the following reasons: a. Patient fails to pay the direct primary care dues under the terms required by this direct primary care agreement b. Patient performs an act that constitutes fraud c. Patient repeatedly fails to comply with a recommended treatment plan d. Patient is abusive and/or presents an emotional or physical danger to the staff or other patients; or e. The provider discontinues operations as a direct practice f. Provider feels you may not be a good fit for their clinic In the event that we elect to terminate this direct primary care agreement under this section, we will provide patient with notice and opportunity to obtain care from another provider. If patient cancels membership twice within one year, the provider reserves the right to deny acceptance of patient into the provider's direct primary care membership at their clinic.		
Let us know...		

I am cancelling my membership (check all that apply)

- ☐ I can't afford the membership dues
- ☐ I'm Moving
- ☐ I want to change my doctor/provider
- ☐ Customer Service
- ☐ I wasn't using the services enough to justify the cost.
- ☐ Other _____

Your Signature

Print Name:

Signature:

Date:

QUESTIONS: 704-240-5260

FAX: 704-703-6607

1220 N. FLINT ST. LINCOLNTON, NC 28092

Additional Memberships to be Cancelled

Adult									
Last Name:			First Name:				Middle Initial:		
Date of Birth:			Sex: ☐ Male ☐ Female			Phone: ()			
Child #1									
Last Name:			First Name:				Middle Initial:		
Date of Birth:			Sex: ☐ Male ☐ Female			Phone: ()			
Child #2									
Last Name:			First Name:				Middle Initial:		
Date of Birth:			Sex: ☐ Male ☐ Female			Phone: ()			
Child #3									
Last Name:			First Name:				Middle Initial:		
Date of Birth:			Sex: ☐ Male ☐ Female			Phone: ()			
Child #4									
Last Name:			First Name:				Middle Initial:		
Date of Birth:			Sex: ☐ Male ☐ Female			Phone: ()			
Office use only:									
Cancellation Date:						Pt. DB updated (initials)			