Direct Primary Care Membership Cancellation Form

EverMed D|P|C

Membership to be Cancelled

Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: □ Male □ Female	DPC # (from your Direct Primary Care card):
Home Address:	City: State:	ZIP:
Phone: ( )		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 EverMed Services, LLC 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 PO Box 453 Camas, WA 98607 or through our website. We recommend that you mail the cancellation notice by certified mail and keep a record for you 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. If this occurs, EverMed DPC will refund the additional billing. 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 want to change my doctor/provider
□ I wasn't using the services enough to justify the cost.
□ Other _____
□ I'm Moving
□ Customer Service

Your Signature

□ I have read, understand, and agree with the Cancellation Policy.
□ I have had an opportunity to ask Provider's staff any questions I have.
□ I want to cancel my membership to the Direct Primary Care program using EverMed Service LLC participating clinics.

Print Name:	
Signature:	Date:

Questions 800.377.6099
Please mail or fax this form to: EverMed DPC

FAX (360) 838.1081
PO Box 453 Camas, WA 98607

Additional Memberships to be Cancelled										
Adult	Last Name:			First Name:					Middle Initial:	
	Date of Birth:		Sex: □ Male □ Female			DPC # (from Direct Primary Care card):				
	Alternate Phone (If different from above): ( )									
Child #1	Last Name:			First Name:					Middle Initial:	
	Date of Birth:		Sex: □ Male □ Female			DPC # (from Direct Primary Care card):				
	Alternate Phone (If different from above): ( )									
Child #2	Last Name:			First Name:					Middle Initial:	
	Date of Birth:		Sex: □ Male □ Female			DPC # (from Direct Primary Care card):				
	Alternate Phone (If different from above): ( )									
Child #3	Last Name:			First Name:					Middle Initial:	
	Date of Birth:		Sex: □ Male □ Female			DPC # (from Direct Primary Care card):				
	Alternate Phone (If different from above): ( )									
Child #4	Last Name:			First Name:					Middle Initial:	
	Date of Birth:		Sex: □ Male □ Female			DPC # (from Direct Primary Care card):				
	Alternate Phone (If different from above): ( )									
Office use only:										
Cancellation Date:		Pt. DB updated: (initials)				GC Acct updated: (initials)				