Direct Primary Care Membership Cancellation Form

EverMed D|P|C

Membership to be Cancelled			
First Name	Last Name		MI
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 will cancelled on the last dat of the month after cancellation notice unless a later date is requested.	**Effective date of cancellation:**

Cancellation Policy

Direct Primary Care / Retainer Medical 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.

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.**
□ **I'm Moving**
□ **Customer Service**
□ **Other _____**

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 EverMed Services participating DPC clinics.

Print Name:	
Signature:	Date:

Please mail or fax this form to:

EverMed DPC
PO Box 453
Camas, WA 98607
Fax: (360) 838-1081

Questions: 800-377-6099

Additional Memberships to be Cancelled			
Spouse/ Domestice Partner	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		
Dependent	Last Name:	First Name:	Middle Initial:
	Date of Birth:		

Office use only:			
Cancellation Date:	Pt. DB updated: (initials)	Date updated:	