WIREGRASS Direct Primary Care | HOW MEDICINE SHOULD BE

# Direct Primary Care Membership Cancellation Form

## 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 30 days from the date that Wiregrass DPC, 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 canceled at any time and for any reason. You can cancel your membership by providing written notice to us at 2726 Windguard Cir, Suite 102, Wesley Chapel, FL 33544 or through our website. We recommend that you email the cancellation notice 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 copy for your records.**

**Per the WDPC agreement when a cancellation occurs, there may be one more monthly billing due as well as we will total the amount of services received verses the amount of membership dues paid which could result in an additional amount due at the cancellation period. If this occurs you will receive one last invoice via email with a itemized statement of services rendered and if it is within 6 months of your initial contract there will be a $200 hold placed on your credit card on file until the account is settled. This amount resets at each individual contract date renewal.**

**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.**

**g. 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.**
**☐ 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.**

Will Wiregrass Direct Primary Care, and it's providers continue to be your Primary Care Provider of Record? ☐ YES ☐ NO

| | |
|---|---|
| Print Name: | |
| Signature: | Date: |

**Questions 813-999-0505**
**Please email or fax this form to: Wiregrass DPC**
**FAX (813) 701-9450**
**email: membership@wiregrassdirectprimarycare.com**

| 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: | | | | | | | | | | Amount Due |
| Cancellation Date: | | | Pt. DB updated: (initials) | | | GC Acct updated: (initials) | | | | |