STORY FAMILY MEDICINE, INC
DIRECT PRIMARY CARE
MEMBERSHIP TERMINATION FORM

_____ (Name of Patient) am terminating my membership in the Story Family Medicine, Inc.'s ("Practice") Direct Primary Care Program ("Program") for the following reason(s):

_____

_____

Section 14 of the Membership Agreement I executed with Practice requires that I submit this form either in person or via email to: hello@storyfamilymed.sprucecare.com thirty days prior to the date I want to terminate from the Program. I further understand and agree that I shall be responsible for verifying with Practice that this form was received thirty (30) days prior to the date I want to terminate from the Program.

If I submit this form within the 30-day billing cycle, I understand that it will result in a final monthly membership fee being auto-charged on my established auto-draft date. This will entitle me to a final 30 days of Program Services.

If I choose to become a member of the Practice's DPC Program in the future, I understand that I will be required to execute a new DPC Membership agreement, re-enroll in the Program, and pay a re-enrollment fee.

_____
Signature of Patient or Parent or Legal Guardian

_____
Name of Patient or Parent or Legal Guardian

Date: _____

Office Use Only
_____ Billing stopped in HINT
_____ Patient deactivated in Spruce
_____ Term Form filed in Elation