CAROLINA FAMILY CHIROPRACTIC LLC

keeping the backbone of your family healthy

----------Section 1: To be completed by member:----------

Date:_____ Name:_____

Phone: _____ Email:_____

Reason for Cancellation:_____

_____

----------Section 2: Member Signature:----------

Member may cancel his/her membership upon providing this Cancellation of Membership Notice to Carolina Family Chiropractic. If this form is not submitted 48 hours prior to billing, one more payment will be billed as agreed upon in the initial membership document. Member will have 30 days to use the remaining visits associated with the membership of his/her account. (e.g., if the member signs up on March 26 and he/she cancels on May 1, the member will have until May 25 to use the remaining visits associated with his/her membership). Individual family members may cancel their membership, but will cause the family membership to cease, unless there are at least two remaining family members. All cancellation notices must be signed and dated and sent by certified mail, return receipt requested or be hand-delivered to Carolina Family Chiropractic. The monthly membership fee(s) for some or all members of a family plan may increase if one of the family members cancels his/her membership.

By signing below I, _____, acknowledge that I understand and accept the cancellation terms, conditions, and procedures stated above, that the dates below have been explained to me and that upon termination of my membership, I will not receive any further benefits of Membership.

----------Section 3: To be Completed By CFC Team Member----------

Member Since: _____/_____/_____

Final ARB Date: _____/_____/_____

Membership Cancellation Request Date:_____/_____/_____

Membership Termination Date:_____/_____/_____.

Employee Name:_____ Employee Signature:_____