The Manette Clinic
1100 Wheaton Way Ste F, Bremerton, WA 98310
Phone (360) 621-2696 | Fax (844) 602-4646
www.TheManetteClinic.com

MEMBERSHIP CANCELLATION FORM

1. CURRENT PRIMARY MEMBER INFORMATION PLEASE PRINT

First Name _____ MI _____ Last Name_____

Address _____

City _____ State _____ Zip _____ Birthdate _____

Phone_____ Email_____

2. PLEASE TELL US YOUR REASON FOR CANCELLING

- ○ Change to your insurance
- ○ Financial
- ○ Moved
- ○ Personal preference
- ○ Care issue (Please provide details so we can improve.) _____
  _____
- ○ Other _____

Additional Comments:_____

3. BILLING INFORMATION AND SIGNATURE

Per The Manette Clinic's signed Patient Agreement, a 30-day notice is required to cancel the account. In order to not be charged for an additional month, the cancellation notice must be signed and received by the 15th of the previous month. If the cancellation notice is received after the 15th of the previous month, then you will be charged for an additional month.

Cancellation Takes Effect the Last Day of the Month _____/_____/_____

4. SIGNATURE_____ DATE_____

For Office Use Only

Date received _____/_____/_____ **Date of final payment_____/_____/_____**

Final date of membership _____/_____/_____ **Staff initials _____**