CHESAPEAKE
ENDOCRINOLOGY

2191 Defense Hwy Suite 308. Crofton, MD. 21114
Phone: 410-216-4445 Fax: 410-314-4547

Membership Cancellation Form

1. **Membership Cancellation**
    a. Please complete and submit this form as notification to cancel your Chesapeake Endocrinology membership. Please review all the information below regarding our cancellation process before submitting the form.
2. **Notification to Cancel Membership Procedure and Policy**
    a. In accordance with Chesapeake Endocrinology Policies and Procedures, I am hereby giving my written notice of cancellation. I understand that membership and billing are not based on usage. Members are responsible for all monthly fees until Chesapeake Endocrinology receives written notice of your intent to cancel once the initial agreement period has been reached.
        i. This notice must be received sixty (60) days prior to the anniversary date of the membership effective date.
        ii. All balances must be paid in full prior to cancellation.
        iii. I authorize Chesapeake Endocrinology to cancel my membership on the date listed below.
        iv. I understand that if I wish to rejoin at a later date, I will have to pay a new registration fee and execute a new Membership Agreement.

Membership to be canceled
First Name_____ **Last Name**_____
D.O.B_____ **Email**_____ **Phone**_____
Home Address_____
Effective Date of Cancellation_____

I am canceling my membership (check all that apply)

- ☐ I can't afford the membership dues
- ☐ I am moving
- ☐ I wasn't using the services enough to justify the cost
- ☐ I want to change my doctor
- ☐ Customer service
- ☐ Other _____

I have read and agreed to the above information.

Patient's Name (print)_____ **D.O.B**_____
Patient's Signature_____ **Date**_____