comprehensive
wellness

MEMBERSHIP AGREEMENT

I have engaged Comprehensive Wellness and the physician indicated below to provide primary care services to me/us for a period of one year. As used in this Agreement, the term "Service Year" refers to the one-year period beginning on March 15, 2020.

PRIMARY CONTACT INFORMATION

Last Name:	First Name:	Middle Name:	
Mailing Address:			
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		DOB:	Sex:

FEES

Fees for the Comprehensive Wellness Membership programs are as follows.

Bronze Membership	Silver Membership	Gold Membership	Platinum Membership
$1,000	$3,500	$6,000	$50,000
CW-You Classes	*Primary Care Physician* *CW-You Classes*	*WorldClinic* *Primary Care Physician* *CW-You Classes*	*All inclusive*

Payment is due in full by March 15, 2020. Membership continues unless we receive written request to opt out of membership.

ENROLLED MEMBER INFORMATION

Please complete the following information for each enrolled family members:

Patient Name (First, Middle, Last)	Patient Email Address:	
Date of Birth:	Select Primary Care Physician: ☐ Dr. Denise Hilliard ☐ Dr. Julia Hohman ☐ Dr. Alph Wise ☐ Dr. Rebecca Parish (*open to renewals only*)	Select Plan: ☐ Bronze ($,1000) ☐ Silver ($3,500) ☐ Gold ($6,000) ☐ Platinum ($50,000)

Patient Name (First, Middle, Last)	Patient Email Address:	
Date of Birth:	Select Primary Care Physician: ☐ Dr. Denise Hilliard ☐ Dr. Julia Hohman ☐ Dr. Alph Wise ☐ Dr. Rebecca Parish (*open to renewals only*)	Select Plan: ☐ Bronze ($,1000) ☐ Silver ($3,500) ☐ Gold ($6,000) ☐ Platinum ($50,000)

Patient Name (First, Middle, Last)		Patient Email Address:
Date of Birth:	Select Primary Care Physician: ☐ Dr. Denise Hilliard ☐ Dr. Julia Hohman ☐ Dr. Alph Wise ☐ Dr. Rebecca Parish *(open to renewals only)*	Select Plan: ☐ Bronze ($,1000) ☐ Silver ($3,500) ☐ Gold ($6,000) ☐ Platinum ($50,000)

Patient Name (First, Middle, Last)		Patient Email Address:
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Patient Name (First, Middle, Last)		Patient Email Address:
Date of Birth:	Select Primary Care Physician: ☐ Dr. Denise Hilliard ☐ Dr. Julia Hohman ☐ Dr. Alph Wise ☐ Dr. Rebecca Parish *(open to renewals only)*	Select Plan: ☐ Bronze ($,1000) ☐ Silver ($3,500) ☐ Gold ($6,000) ☐ Platinum ($50,000)

SUMMARY

Bronze Memberships	_____	x $1,000	=	________________
Silver Memberships	_____	x $3,500	=	________________
Gold Memberships	_____	x $6,000	=	________________
Platinum Memberships	_____	x $50,000	=	________________
		TOTAL DUE	=	________________

METHOD OF PAYMENT

☐ Personal Check Please make payable to *Comprehensive Wellness Membership*	☐ Credit Card Name on Card: ____________________________________ Credit Card Number: ________________________________ Expiration Date: ____________________ CVV Code: ______ I hereby authorize Comprehensive Wellness to charge my credit card an amount equal to the fee(s) indicated above. This card will be charged annually on March 15 unless we receive payment via personal check prior to March 15. Signature: ____

AGREEMENT

I acknowledge that either Comprehensive Wellness or I can terminate this Agreement upon 30 days written notice. If Comprehensive Wellness terminates the agreement, I will receive a refund of the prorated portion of the paid Annual Fee, based on the number of days that have elapsed in the Service Year. Such a refund would be paid to me within 30 days of termination.

I may renew this Agreement for subsequent Service Years by paying the annual fee for the applicable year as determined by Comprehensive Wellness Membership.

Please print and sign names (all member patients):

Printed Name:	Signature:	Date:
Printed Name:	Signature:	Date:
Printed Name:	Signature:	Date:
Printed Name:	Signature:	Date:
Printed Name:	Signature:	Date:

Please send your completed and signed form to Comprehensive Wellness:

Comprehensive Wellness
attn: Membership
110 La Casa Via, Suite 205
Walnut Creek, CA 94598