



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
\$1,000

Silver Membership
\$3,500

Gold Membership
\$6,000

Platinum Membership
\$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: <input type="checkbox"/> Dr. Denise Hilliard <input type="checkbox"/> Dr. Richard Kamrath <input type="checkbox"/> Dr. Rebecca Parish <i>(open to renewals only)</i>	Select Plan: <input type="checkbox"/> Bronze (\$1,000) <input type="checkbox"/> Silver (\$3,500) <input type="checkbox"/> Gold (\$6,000) <input type="checkbox"/> Platinum (\$50,000)

Patient Name (First, Middle, Last)		Patient Email Address:
Date of Birth:	Select Primary Care Physician: <input type="checkbox"/> Dr. Denise Hilliard <input type="checkbox"/> Dr. Richard Kamrath <input type="checkbox"/> Dr. Rebecca Parish <i>(open to renewals only)</i>	Select Plan: <input type="checkbox"/> Bronze (\$1,000) <input type="checkbox"/> Silver (\$3,500) <input type="checkbox"/> Gold (\$6,000) <input type="checkbox"/> Platinum (\$50,000)

Patient Name (First, Middle, Last)		Patient Email Address:	
Date of Birth:	Select Primary Care Physician: <input type="checkbox"/> Dr. Denise Hilliard <input type="checkbox"/> Dr. Rebecca Parish <input type="checkbox"/> Dr. Richard Kamrath (open to renewals only)		Select Plan: <input type="checkbox"/> Bronze (\$,1000) <input type="checkbox"/> Silver (\$3,500) <input type="checkbox"/> Gold (\$6,000) <input type="checkbox"/> Platinum (\$50,000)

Patient Name (First, Middle, Last)		Patient Email Address:	
Date of Birth:	Select Primary Care Physician: <input type="checkbox"/> Dr. Denise Hilliard <input type="checkbox"/> Dr. Rebecca Parish <input type="checkbox"/> Dr. Richard Kamrath (open to renewals only)		Select Plan: <input type="checkbox"/> Bronze (\$,1000) <input type="checkbox"/> Silver (\$3,500) <input type="checkbox"/> Gold (\$6,000) <input type="checkbox"/> Platinum (\$50,000)

Patient Name (First, Middle, Last)		Patient Email Address:	
Date of Birth:	Select Primary Care Physician: <input type="checkbox"/> Dr. Denise Hilliard <input type="checkbox"/> Dr. Rebecca Parish <input type="checkbox"/> Dr. Richard Kamrath (open to renewals only)		Select Plan: <input type="checkbox"/> Bronze (\$,1000) <input type="checkbox"/> Silver (\$3,500) <input type="checkbox"/> Gold (\$6,000) <input type="checkbox"/> 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

<input type="checkbox"/> Personal Check Please make payable to <i>Comprehensive Wellness Membership</i>	<input type="checkbox"/> 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: _____
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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