Assurance
Healthcare & Counseling Center

Service Cancellation Form

When completed, please return form to Assurance Healthcare & Counseling Center via:
Fax: (509) 823-4652 | Email: info@assurancehealth.org
Mail or Drop off: 1020 S. 40th Ave. Suite A – Yakima, WA 98908

Patient Information:

Name: _____Date of Birth: _____

Address: _____

Membership Cancellation Date: _____

Service cancellation is effective of the last day of your current billing cycle unless otherwise specified (the earliest effective date is the date Assurance Healthcare & Counseling Center receives this form).

I am cancelling my Assurance Healthcare & Counseling Center membership because:

☐ Moving out of the area ☐ Dissatisfied with service ☐ Job related
☐ Financial Considerations ☐ Transferring Care
☐ Other (please explain…) _____

Authorization:

I am choosing to cancel my Assurance Healthcare & Counseling Center membership. As per the Patient Services Agreement…

- I understand that my current monthly membership fee payment entitles me to receive Assurance Healthcare and Counseling Center services until the end of the current pay period (the day before the next billing due date).
- I understand that if I have made any pre-payments beyond the current monthly service period, they will be pro-rated to the date of cancellation and refunded to me within ten (10) business days.
- I understand that at any time from this day forward, I may request a copy of my patient medical record for myself or on behalf of another physician or individual.
- I understand that as of the end of my membership, I will not be able to access any of the services offered by Assurance Healthcare & Counseling Center.
- I understand that I may re-join Assurance Healthcare & Counseling Center at any time under the terms and conditions for registration at that time.
- I understand that an enrollment fee will be applied to my account if I choose to re-start my Assurance Healthcare & Counseling Center membership at a future date.
- I understand that if I am cancelling prior to my 6 month minimum membership agreement, early termination fees may apply.

Signature: _____Date:_____

Printed Name: _____
Signature by: ☐Patient ☐Parent ☐Legal Guardian