RENEWED WELLNESS
107 N SR 135 STE 202
GREENWOOD, IN 46142
317-348-3444

Membership Cancellation Request

Patient Name: _____

Patient MRN: _____

DOB: _____

Today's Date: _____

I hereby wish to **CANCEL** my annual membership with Renewed Wellness, LLC.

The Original fee is non-refundable and non-transferable per our original agreement. This cancellation is effective as of today's date, and I will no longer have access to the membership privileges going forward.

Signature: _____

Date: _____