Quality Medicine LLC, W. Scott Curtice MD

3 Crestview Dr., Lower Level
Westerly, RI 02891
Office (401) 602-7031 Fax (877)651-1396
QualityMedicineRI@gmail.com

MEMBERSHIP AGREEMENT

Membership Agreement with Quality Medicine LLC and;

_____ ____/____/____ M F

NAME **DOB** **SEX**

_____

_____

ADDRESS **HOME #**

_____ _____

_____

EMERGENCY CONTACT **PHONE #** **RELATIONSHIP**

CONDITIONS

I understand that my monthly dues will be drafted each month from my account listed below. Monthly dues as agreed upon are $_____/ month or $_____ yearly.

Credit Card#_____ EXP _____/_____ CVV_____

TERMS

The Membership period starts on_____ and will remain in effect until cancelled.

(TODAY'S DATE)

CANCELLATION POLICY

If you wish to cancel your membership, you may do so in writing and deliver in person or via certified mail to Quality Medicine LLC. A member has the right to cancel this contract under certain circumstances 30 days in advance. Quality Medicine LLC may be entitled to retain a certain portion of the money paid based on services provided and at the discretion of the owner, Walter Scott Curtice MD.

My signature below indicates that I have read and understand the above relating to payment for membership. Any question or concerns, please feel free to ask DR Curtice or Quality Medicine LLC staff.

Member's Signature_____**DATE**____/____/____