Primary Care Simplified Aesthetics and Wellness Membership Agreement

This membership agreement between Primary Care Simplified and _____ (member name) shall be effective on the date of _____.

The type of membership selected is **Aesthetic, Wellness** (circle one). Monthly payments for this membership shall occur on the 1st of each month in the amount of $_____. The member also has the option to pay for the membership in full at the time of enrollment.

Membership Term:

1. **The initial membership period shall be for a period of six months** (the "Initial Period"). A member shall not be entitled to terminate or suspend his/her membership during the initial period. If the contract is terminated before the expiration date, this is an **early termination fee of $150** that will be charged to the card on file.
2. At any point within your contract you may upgrade to a higher tier, however, you may not downgrade while you are in the "initial period." If you would like to downgrade your membership after your initial period you may do so at any time by giving a 30 day written notice to Primary Care Simplified.
3. After the Initial Period, the membership shall automatically renew for a six-month period. Either party may cancel the membership at any time by giving a 30 day written notice to the other party.
4. This Agreement is personal to the member(s) and may not be assigned, transferred or otherwise disposed of by the member(s).

Automatic Payment Agreement:

1. Monthly membership **payments will be auto charged on the 1st of every month** from the member's designated credit/debit card on file.
2. The member is responsible to ensure the credit card number on file with Primary Care Simplified is valid and current. If there is not a valid credit card on file at the time the monthly fee is charged suspension of the membership will occur until payment is made in full.
3. Primary Care Simplified reserves the right to review subscriptions periodically. Members will be given at least a 30 days' notice in writing of any changes, which include: (i) any increase in membership fee, (ii) change in date of automatic withdrawal.

Scheduling Policy

A **minimum 24-hour notice is required to cancel or reschedule** an appointment. If such notice is provided, your scheduled treatment will not be forfeited. Failure to provide 24-hour notice or not showing up to your appointment, will result in forfeit of that service.

Primary Care Simplified does not provide service rollovers. It is recommended you schedule your next month's appointment while in the office. If you fail to schedule your monthly appointment, you will lose out on your membership service for that month and still be charged your monthly fee.

Termination or Suspension of Membership:

Primary Care Simplified reserves the right at any time to cancel or suspend the membership of any member in the event of the following:

- The member commits a serious breach of this Agreement and/or Primary Care Simplified Rules and Regulations.
- Where any monies are due to Primary Care Simplified by the member remain unpaid for 30 days after its due date for payment.

- The member knowingly provides false details when applying for membership and the false declaration would have reasonably affected Primary Care Simplified's decision to grant the membership.
- If Primary Care Simplified terminates for any reason, they reserve the right to retain any monies received to cover any reasonable costs they have incurred as a result.

Terms and Conditions:

1. Primary Care Simplified reserves the right to vary, add or eliminate any of the particular services and facilities provided from time to time.

2. Primary Care Simplified reserves the right to set aside facilities for social events or activities.

3. Primary Care Simplified reserves the right to close or modify facility hours with or without notice.

4. May not be combined with any other promotional offer or promotional gift card.

I hereby agree to the Membership Agreement as stated above.

_____ _____ Print Name Date

_____ _____ Signature Date

Credit Card Authorization

Type of Card: _____

Card Number: _____--_____--_____--_____

Expiration Date: _____/_____

CCV Code (three digits on back of card): _____

Cardholder Name: _____

Billing Address: _____

_____

Email Address: _____

I hereby authorize Primary Care Simplified to charge my card above per the terms of this membership agreement.

_____ _____ Signature/Date