SWEDISH

SWEDISH FAMILY MEDICINE – BALLARD

Self-Pay Program Cancellation Form

Patient name: ______________________________ Patient date of birth: ____________

Cardholder name (if different than above): ______________________________

Name of parent or guardian: ______________________________

Cancellation:

I am cancelling my Swedish Family Medicine – Ballard membership because:

- ☐ Moving out of the area
- ☐ New insurance coverage

  Plan name: ______________________________ Subscriber ID: ____________
- ☐ Financial considerations
- ☐ Transferring care
- ☐ Other, please explain: ______________________________

Authorization:

I am choosing to cancel my patient membership with Swedish Family Medicine – Ballard. Per the *Patient Agreement:*

- ☐ I agree that if my enrollment was less than the minimum period of 6 months, I will be charged a $200 early termination fee.
- ☐ I understand that if I have received services this month, my final payment will be on the first of next month
- ☐ I understand that I still have the right to be a patient of Swedish Family Medicine – Ballard, but that I cannot re-enroll in the self-pay program for a minimum of 6 months. If I would like to make an appointment, I will have to provide proof of insurance or alternate means of payment.

Signature: ______________________________ Date: ____________

For office use only:

- ☐ Patient given copy

Patient MRN: ______________________________

Patient Account #: ______________________________

- ☐ Cancelled in Database
- ☐ Cancelled in Your Pay
- ☐ Scanned to Chart