FitMD

Nutrition Exercise Hormone Therapy

Member Details

*Name:*_____ *Phone:*_____

*Address:*_____ *City:*_____ *State:*_____

Sex: ☐ *Male* ☐ *Female* *Birthday:*_____/_____/_____ *Email:*_____

Membership Type

Monthly Payment....._____

Number of Payments....._____

Total Amount....._____

Last Payment Date.....___/_____/____

Membership Declaration

Before signing this document, I have read, understand, and hereby agree to the terms and conditions of this membership form and know that it affects my legal rights. I agree to pay the following each month until the end of my term is completed, or I have paid the cancellation fee.

Please complete the card information below, which authorizes FitMD to debit the following card for the above membership each month

*Name(as it appears on card):*_____

*Card Number:*_____ *Expiration:*_____/_____ *CVV:*_____

*Billing Address (if different from above):*_____ *Zip Code:*_____

*Signature:*_____ *Date:*_____/_____/_____

Terms and Conditions

- *Cancellation of contract will require 2 monthly payments to be made with no services given.*
- *Client hereby agrees to pay to provider all monies due and woing for any and all services rendered on his or her behalf. Client acknowledges that, in the event of defualt, total contract price will be due and owing.*

By signing, I accept these terms and conditions.

*Signature:*_____ *Date*_____/_____/_____