Nuviva®
Medical Weight Loss

Cancellation of Membership Services

I _____ ,voluntarily wish to discontinue my membership with Nuviva Medical Weight Loss as of _____/_____/_____. I agree to discontinue the use of any and all medications provided to me while under the care of the clinic. I realize the medications that were provided to me during my treatment at the clinic were intended to be used only while under the medical care and direction of the clinic. I will contact my primary care physician if any medical conditions arise after my discontinuation of services with the clinic and seek treatment from my primary care physician.

This cancellation form will also act as a written termination request as required and set forth in the credit card authorization agreement.

_____ _____

SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

It's Not Just a Diet. It's a New Life!