



RENEWED WELLNESS
107 N SR 135 STE 202
GREENWOOD IN 46142
317-348-3444

Membership Cancellation Request

Patient Name _____

Patient MRN _____

DOB _____

Today's date _____

I hereby wish to CANCEL my annual membership with Renewed Wellness, LLC.

The original fee is non-refundable and non-transferable per our original agreement. This cancellation is effective as of today's date, and I will no longer have access to the membership privileges going forward.

Signature _____ Date _____