all about you
Health Management Membership Agreement

AUTO-PAY MONTHLY AGREEMENT– DEBIT / VISA / MC / AMEX / DISCOVER (circle one)
WITH 6-MONTH MINIMUM COMMITMENT.

_____ I understand the monthly fee of **$85 for Premium Membership or $110 for Elite Membership** will be deducted from my account today, and in advance from my Visa/MC/AMEX/Discover for the upcoming month. Your membership fee will be deducted monthly from the date of this agreement (or next banking day if banks are closed on that date) for a **minimum of SIX consecutive months**, ***after which fees will continue to be deducted monthly until I cancel my Auto-Pay Health Management Membership with a 30-day advance written notice***.

_____ I understand if fees are insufficient they will be re-submitted to my credit card and the billed to my home address along with a $25 insufficient fund fee. Membership services are not available for use until account is brought current.

_____ Balances still due 10 days after the due date will be charged a $4 late fee. Past due accounts are subject to collections.

_____ **This agreement has a minimum 6-month term. I may terminate this contract during the first 6-months with a 30 day written notice and the payment of a $75.00 cancellation fee.**

_____ After the initial six months your continuous Health Management Membership will continue indefinitely until you cancel with a 30-day written notice. **Cancellation notices are to be sent to info@ALLaboutYOUsolutions.com.**

_____ **I understand that I am signing a contract with all about you (AAY LLC)** and agree to pay for my continuous Health Management Membership for the specified period of time, **this contract is binding and I understand I will receive no refunds and that this is a continuous Health Management Membership with no extensions for non-use.**

_____ I understand if this account is ever deemed "past due", and subsequently turned over to a collection service, I agree to pay all collections fees in addition to my obligation to ***all about you***.

_____ I have a read and understand the continuous Health Management Membership program details as defined in the program brochure.

_____ I understand that my continuous Health Management Membership program is valid for my personal use only other than as defined in the Health Management Membership program brochure.

_____ I understand that services are by appointment only and that there is no guarantee that my preferred therapist will be available.

_____ I understand as per our existing policy, a 24-hour notice is required for appointment changes. Failure to provide notice will result in the use of my membership to compensate the therapist for the missed appointment.

_____ I have received a copy of this agreement for my records.

Billing Address ____

Telephone ____ Email ____

Signature of person responsible for maintaining account: **Total Amount Paid Today $____________**

X____ ***SCANNED COPY ACCEPTED AS IF IT WAS ORIGINAL***

Date:______________________ Staff_________________________________

Credit card information is destroyed after initial processing.

Name as it appears on card ____ CVV Code _________________________

CC # ____ Exp. Date (mmyy) __________________