



## Membership Agreement

Full Name:

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code:

\_\_\_\_\_

Email Address:

\_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Alternate  
Phone: \_\_\_\_\_

Select your desired membership level:  Water  Land  Sky

Choose your minimum membership period:  6 months  12 months

I agree to subscribe to the Bay Wellness membership program and commit to a minimum membership period of  6 months,  12 months. I understand that my chosen membership tier will incur the following monthly fees:

-  WATER Membership - \$50 per month

-  LAND Membership - \$35 per month

-  SKY Membership - \$20 per month

I authorize Bay Wellness (Bayboro Pharmacy) to store and charge my credit card monthly for the selected membership tier. In case of any changes to my payment information, I will promptly update my details.

\*\*\*Pay your 6 month or 12 month membership up front and get 1 month free! \*\*\* I agree to receive SMS messages from Bay Wellness for important updates and promotions. I agree to receive email communications from Bay Wellness for newsletters and promotions.

I hereby acknowledge that I have read and understood the terms and conditions of the Bay Wellness membership program and agree to abide by them.

Signature: \_\_\_\_\_ Date:

\_\_\_\_\_

Thank you for choosing Bay Wellness! We look forward to helping you on your wellness journey.