**Supplemental Contribution Agreement**

I agree to participate in the subscription-based payment model for care received by Dr. Dean Chier, MD. I understand that this is a voluntary out-of-pocket expense contributing towards services rendered that are not a covered benefit under my insurance plan. This includes longer appointment times, email communication, electronic record portal correspondence and other services rendered outside of a scheduled appointment. Participation serves to maintain the small practice size that allows more personalized attention and ready availability offered by Dr. Chier. I also understand that my insurance will continue to be billed in the usual manner for all office visits.

Number Total Amount

- Adults 25 years and older $360 per year \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

- Patients younger than 25. $180 per year \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

- Family or 3 or more patients. $900 maximum per year \_\_\_\_\_\_\_\_\_\_\_\_

- Optional Additional Contribution \_\_\_\_\_\_\_\_\_\_\_\_

Total Annual Payment \_\_\_\_\_\_\_\_\_\_\_\_

(A sliding scale is negotiable on an individual basis as needed by contacting the office.)

# Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Spouse/Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Dependent(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* A Personal Check is enclosed (payable to Dean Chier, MD)

Cardholder Name:

Address:

Card Number: \_ \_ \_ \_-\_ \_ \_ \_- \_ \_ \_ \_-\_ \_ \_ \_

Expiration Date: \_ \_ /\_ \_

CVV: \_ \_ \_

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