



**Dean Chier,
MD**

office 206-906-9786
FAX 206-906-9246
EHR FAX 206-902-2008
info@deanchiermd.com

Lake City Professional Center
2611 NE 125th St., Ste 90
Seattle, WA 98125
www.deanchiermd.com

Membership Contribution Agreement

I agree to participate in the membership practice for care received by Dr. Dean Chier, MD. I understand that this is a completely voluntary out-of-pocket expense for the added services I have appreciated that are not a covered benefit under my insurance plan. This includes email communication, electronic record portal correspondence and other services rendered outside of a scheduled appointment. This supplemental payment serves to help maintain the small practice size that allows more personalized attention and spacious appointment times offered by Dr. Chier. I also understand that this is completely separate from my insurance coverage and that my insurance will continue to be billed in the usual manner for all office visits, labs, imaging and other covered benefits.

Membership	Annual Amount	Number	Total
Adult	\$360		\$
Family (1-2) adults and dependents 16-24 years old	\$540-\$900	Adult: Child:	\$
Optional additional contribution			\$
Total			\$

(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: _____