Dean Chier, MD

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Membership Contribution Agreement

I agree to participate in the membership practice for care received by Dr. Dean Chier, MD. I understand that this is an out-of-pocket expense contributing towards services rendered 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. Membership participation serves to maintain the small practice size that allows more personalized attention and spacious appointment times offered by Dr. Chier. I also understand that my insurance will continue to be billed in the usual manner for all office visits.

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