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Family Plan Agreement

I have read and agree to the family plan fee. I understand that this fee is for non-clinical services which are not covered or reimbursable by my insurance plan.

The cost of the annual fee is:

Families with one child: \$100 per year

Families with two or more children: \$200 per year

This fee is optional and will be collected at the first visit of 2022 and will renew on that date every year thereafter, any patient can opt out after fee is paid with no penalty.

If you would like to pay the fee in advance, it will still begin at the first visit of 2022.

Please list your child/children below and their primary doctor:

Child's Name: _____ Date of Birth: _____ PCP _____

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Child's Name: _____ Date of Birth: _____ PCP _____

Enclosed is my payment of \$ _____

- Check (make payable to child's PCP)
- Credit/Debit card

Name on card: _____

Credit Card #: _____

Exp Date: _____

Security Code: _____

Billing Zip Code: _____

Print Name: _____ Relationship: _____

Phone Number: _____

Signature: _____ Date: _____

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