**2017 Annual Fee Payment**

Last Name, First Name: _______________________________________________

Family Members *also current patients*:_________________________________________

_________________________________________________________________________

Total: **(circle option)**

**Individual:** $15.00

**Two patients:** $30.00

**Family Option**: Multiple siblings, or combined parents and dependent children - $40.00

I, the undersigned, **agree to pay** Mountain View Internal Medicine & Pediatrics an annual fee (one time per year, not per office visit) for “non-covered” services which include administrative fees, electronic communication, postage, form completion, and other services which incur expenses over and above the traditional “office visit” costs**. I understand that this fee does not apply to insurance co-pays, deductibles or the cover charges for missed appointments.**

_________________________________________________________________________

Signature Date

**Opt Out Agreement**:

I, the undersigned, elect **not to pay** Mountain View Internal Medicine & Pediatrics’ annual Administration fee. I understand that if I elect not to pay this fee; I will pay for additional services as I need them according to the schedule of fees provided to me.

_________________________________________________________________________

Signature Date

Payment Type:_______________
Amount:____________________
Staff Name & Date:__________________