I, the undersigned agree to the Valley Pediatric Medical Group annual administrative fee. I understand that the annual administrative fee must be paid and renewed yearly in order to continue to receive benefits not covered or not reimbursed by my insurance plan.

I am aware that additional children in the family will automatically be added. I agree to pay the additional cost within 15 days after a new child is added to my family.

All administrative fees are due each year at the first visit to the office of the year.

The cost of the annual administrative fee is:

- Families with one child- $100.00 per year
- Families with two children- $200.00 per year
- Families with three or more children- $250.00 per year

I have read and understand the administrative fee information and agree to the terms of Valley Pediatric Medical Group's annual administrative fee policy. I agree to pay this fee for items and services not covered and not reimbursed by my insurance plan. I understand that this fee cannot be billed to insurance.

Parent/Guardian Signature: _____ Date: _____

Relationship_____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Amount Enclosed $_____

Unfortunately, your insurance will NOT pay these fees. However, if you have a Flexible Spending Account, it may be covered.

If you would like to pay by credit card, please complete the section below. Please return entire form with your payment.

Card Holder's Name (as shown on card):_____

Signature of Card Holder: _____ Date: _____

Credit Card Number_____ Exp. Date (MM/YY) _____

Card Type [ ] VISA [ ] MASTERCARD [ ] AMEX [ ] HSA CARD

CVV Code: _____ Billing Zip Code _____