9 COMMONS STREET,
RUTLAND, VT 05701
(802) 779-7522 Fax: (802) 735-9662

PATIENT AGREEMENT

I have engaged TRUE CARE to provide non-covered primary care services and other amenities and benefits to me. I understand that a yearly membership fee is assessed to pay for these non-covered services, amenities and benefits. As used in this Agreement, the term "Service Year" refers to the 1-year period beginning on the date below as well as every 1-year period after that, to the extent I renew the Agreement as provided below.

PERIOD of ONE YEAR beginning: _____, 20___

I have read and understand this Agreement as well as the "Highlights & Details" and "Frequently Asked Questions (FAQs)" materials provided to me by TRUE CARE. I understand that this Agreement can be terminated upon 30 days written notice. If I terminate, the annual fee may be pro-rated or forfeited, to be determined on a case-by-case basis. If TRUE CARE terminates, I will receive a refund of the prorated portion of the paid annual fee, based on the number of days that have elapsed in the Service Year. Such refund will be paid to me within 30 days after termination.

I may renew this Agreement for subsequent Service Years by paying the annual fee for the applicable service year as determined by TRUE CARE. The terms of this Agreement will apply to all such subsequent Service Years, unless TRUE CARE and I agree otherwise, in writing.

✓ _____/_____/_____

PATIENT Signature | Printed Name | Today's Date

_____

E-mail Address

✓ **FOR PATIENT MEMBERSHIP DURING THE SERVICE YEAR, I AGREE TO PAY TRUE CARE Vermont:**

❑ $550/year = Individual

✓ METHOD OF PAYMENT:

❑ Self-Enroll: https://truecarevermont.hint.com/signup

❑ **Personal check** enclosed. Please make check payable to TRUE CARE Vermont
(Full annual payment only) _____ Check Number $ _____.00 Amount

❑ **Debit Card** ❑ **Credit Card** ➔ ○ MasterCard ○ Visa ○ Other

❑ I authorize the payment as indicated above. $ _____.00

I authorize TRUE CARE to automatically charge my credit card the amount(s) indicated above.

_____/_____/_____

Card # | Exp. Date | Security Code

_____/ _____

Cardholder Signature | Cardholder Daytime or Cell Phone Number

_____

Cardholder Billing Address | Billing Zip Code

(This card information will be destroyed (shredded) after processing this transaction)