LAURA BRUCKNER, M.D. ANDREW KRASNOFF, M.D. HELEN LEDERER, M.D.
CATHERINE MARSHALL, M.D. SLOANE SEVRAN, M.D.
MIRIAM CHAN, M.D. JULIA BRUCKNER, D.O. OFIR MEKEL, M.D.

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 will be collected annually on the anniversary of your original payment.

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

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

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

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

Childs's Name: _____ Date of Birth: _____ PCP_____

Childs'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: _____

5400 Balboa Blvd Ste 326, Encino, CA 91316
(818) 789-8775

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