Dr. Daniel Bruckner

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: $500 per year

Each Additional Child: $250 per year

Maximum Per Family: $1000 per year

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

Please list your child/children below:

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Childs's Name: _____ Date of Birth: _____

Childs's Name: _____ Date of Birth: _____

Enclosed is my payment of $_____

- Check (make payable to Dr. Daniel Bruckner)
- 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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