LAURA BRUCKNER, M.D. ANDREW KRASNOFF, M.D. HELEN LEDERER, M.D.
IRWIN BRUCKNER, 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 is optional and will be collected at the first visit of 2023 and will renew on that date every year thereafter, any patient can opt out after fee is paid with no penalty.

If you would like to pay the fee in advance, it will still begin at the first visit of 2023.

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: _________________________

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(818) 789-8775

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