ANN L. ENGELLAND, M.D. pllc 921 W. BOSTON POST ROAD
MAMARONECK, NY 10543

MOTHER'S INFORMATION

LAST NAME______________________ FIRST NAME__________________________
SS#________________________________ BIRTHDATE __________________________
ADDRESS ____
____
HOME PHONE _____________________CELL/WORK PH# ______________________
EMPLOYER _______________________ OCCUPATION ________________________
EMAIL ADDRESS____

FATHER'S INFORMATION

LAST NAME______________________ FIRST NAME__________________________
SS#________________________________ BIRTHDATE __________________________
ADDRESS ____
____
HOME PHONE _____________________CELL/WORK # ________________________
EMPLOYER _______________________ OCCUPATION _________________________
EMAIL ADDRESS ____

INSURANCE CARRIER ___________________ PLAN TYPE ____________________
ID# ________________________________ GROUP # ______________________________
WHO IS THE POLICY UNDER??? MOTHER/FATHER _____________________

We are now accepting Aetna and Hudson Health Plans. **Copays are due at time of visit.**

FINANCIAL AGREEMENT FOR SELF PAY PATIENTS
Payment in full is expected at time of service. For your convenience we accept MC, Visa, Amex, cash or checks. Upon receipt of payment we will immediately give you an encounter form complete with procedure and diagnosis codes that you can use to remit to your insurance company for reimbursement. This payment should go directly to you.

Parents are encouraged to provide their children with a means of payment when they do not accompany them to the office.

Please be advised that there is a $20 fee for all returned (bounced) checks.

Thank you in advance for your cooperation.

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Signature of Responsible Party Date