RAMA E. CHANDRAN, M.D.
SHAUN E. CHANDRAN, M.D.
ORTHOPAEDIC SURGERY
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4477 W. 118TH STREET, SUITE 402
HAWTHORNE, CALIFORNIA 90250

4201 TORRANCE BLVD SUITE 310
TORRANCE, CA 90503

AUTHORIZATION/RESPONSIBILITY AGREEMENT

I hereby authorize any insurance carrier/responsible party to pay the proceeds of any benefits due me directly to

RAMA E. CHANDRAN, MD, INC.
SHAUN E. CHANDRAN, MD, INC.

A copy of this can be considered as an original for insurance purposes.

I acknowledge and understand that I am responsible for all the charges with regard to services rendered to me or any member of my family.

Although I understand that the billing staff will submit my charges to my insurance carrier as a courtesy to me, it will be my responsibility to be sure that the charges are paid within a reasonable period of time. If for any reason, any portions of the submitted charges are not paid by my insurance carrier, I further agree to make arrangements for prompt payment of outstanding charges. Co-pay and deductible will be paid at the time of the service.

I also authorize the release of any medical information necessary to process claim submitted on my behalf.

I also authorize the release of my prescription history from any external sources.

Name of Patient

Signature of Patient or Responsible Party

Date