



Gateway Pediatrics P.L.L.C.
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AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

- I authorize Sudha Chandrasekhar M.D., F.A.A.P. or any other Practitioner employed by Gateway Pediatrics PLLC, to treat my child _____
_____.
- I further authorize the release of medical information necessary for the completion of insurance forms, processing of the claim and receipt of the payments.
- I request payment of government benefits either to myself or the party who accepts assignment.
- I authorize payment directly to Sudha Chandrasekhar M.D., F.A.A.P. and/or Gateway Pediatrics P.L.L.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance.
- I understand that I am fully responsible for all co-payments, co-insurance and for any and all charges not paid or covered by my insurance. I understand that insurance coverage is based on an agreement between me/my employer and my insurance company and billing the insurance company is done as courtesy to me. Gateway Pediatrics expects to be paid in full for all services rendered.
- I have been provided a chance to read through the billing and payment policies. In the event of payment default, I agree to pay all costs of collection, including court fees and reasonable attorney fees and any interest charges that might accrue.
- There will be a charge for returned checks or returned transactions.
- A photocopy of this authorization will be considered as effective and valid as the original.
- Medical care and immunizations cannot be given unless your child is accompanied by one of the following persons:

Name of Parent or Responsible Party _____
Signature of parent or responsible party _____
Date _____