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## Livermore/Pleasanton Pediatrics Group

Infants • Children • Young Adults

### **ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY**

PATIENT/PARENT:

Your signature on this form acknowledges that you agree to bear full responsibility for all services provided as listed below if:

- Your child(ren) are determined not to be eligible for coverage
- The services are not covered under your benefit plan
- The services have not been otherwise referred or authorized as required by your health plan

Patient's Name: \_\_\_\_\_ Insurance for visit: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_ ID# on Ins. Card: \_\_\_\_\_

\_\_\_\_\_  
Patient of legal representative signature Date

\_\_\_\_\_  
Patient or legal representative signature Date

**THIS AUTHORIZATION REMAINS IN FORCE UNTIL REVOKED**

Rev. 4/10