NORMAN B. LIVERMORE III, M.D.

AUTHORIZATION STATEMENT:
I request that payment of authorized benefits be made on my behalf to Norman B. Livermore, M.D. for any services furnished me by physician. I authorize any holder of medical information about me to release and information needed to determine these benefits payable to related services.

SIGNATURE:_____________________________ DATE:_________________

Medicare patients:
We are participating providers in the Medicare program. The physician agrees to accept the Medicare allowed amount as full fee. The patient is responsible only for the deductible, coinsurance, and noncovered services.

Managed Care Patients :(PPO, EPO, POS)
If the physician is on the panel of your health plan, the physician has agreed to accept the plans allowable amount as full fee. The patient is responsible only for the deductible, coinsurance and/or copayment. **EPO, POS PATIENTS ARE RESPONSIBLE TO PROVIDE REFERRAL AUTHORIZATIONS FOR ALL THEIR VISITS.**

Please note that while we will make every attempt to assist you in obtaining the necessary prior authorizations for visits and/or tests, your assistance with this is needed and appreciated. Each plan has rules that we must follow in order to provide you with the best medical care yet not go outside of your plan's parameters. Sometimes this requires patience and a lot of follow-up. If you have questions regarding your specific plan, contact your member service representative for clarification.

Managed care plans require that you utilize the services of specific facilities for tests such as laboratory and x-ray studies. It is imperative that you use the contracting facility to avoid being billed for the services. If you are not sure where you can get these tests done, please ask our staff or call your plan representative.

I hereby acknowledge that I received a copy of this medical practice's Notice of privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of privacy practices (if applicable) at each appointment.

Signature: ______________________________________ Date: ___________________

Print Name: ____________________________________ Telephone: _______________

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] Beneficiary or personal representative of deceased patient

FINANCIAL POLICY:
Payment of copays is required at all time of service. For those which have coinsurance amounts (i.e. Medicare, and PPO's) we will allow you to withhold payments until the insurance has notified us of the coinsurance amount. Your portion is required within thirty days of the insurance companies notification and/or immediately due upon first statement. If you have any questions regarding our policy, please ask for assistance at your visit today or call our office at 925-933-4443.