PULMONARY AND CRITICAL CARE SPECIALISTS
of Northern Virginia, P.C.

GEORGE C. BAZACO, M.D.
JOHN B. CLEARY, M.D., F.C.C.P.
BARRY S. DICICCO, M.D., F.C.C.P.
DEPAK SONI, M.D., F.C.C.P.
THOMAS J. LO RUSSO, M.D., F.C.C.P.
MARLA L. SHUMAN, M.D., F.C.C.P.
RICHARD A. SWIFT, M.D., F.C.C.P.
MAURA P. FOLEY, M.D., F.C.C.P.
JANE J. WU, M.D.
KEVIN L. GLASS, M.D., F.C.C.P.

FAIR OAKS OFFICE
3650 Joseph Siewick Drive
Suite 307
Fairfax, VA 22033-1719
(703) 391-8804

FAIRFAX OFFICE
8503 Arlington Boulevard
Suite 330
Fairfax, VA 22031-4603
(703) 645-2234

RESTON OFFICE
1800 Town Center Drive
Suite 419
Reston, VA 20190-3237
(703) 620-3926

MANASSAS OFFICE
8650 Sudley Road
Suite 212
Manassas, VA 20110-4416
(703) 369-7788

FAUQUIER OFFICE
382 Hospital Drive
Warrenton, VA 20186-3006
(540) 349-8195

BUSINESS OFFICE
3650 Joseph Siewick Drive
Suite 307
Fairfax, VA 22033-1719
(703) 391-8833

Dear Patient:

Your physician has referred you for sleep disorder testing. Interpretation of this testing, diagnosis, and recommendations will be provided by one the sleep physicians of Pulmonary and Critical Care Specialists of Northern Virginia, P.C. Test results will be faxed and mailed to your ordering physician within 10 business days.

Billing for these services will be done separately and independently of the lab where your services are rendered. Any questions regarding this bill should be directed to the Billing Department at 703-391-8833. Billing personnel are available Monday through Friday, 9:00 a.m. – 4:00 p.m.

Please sign below regarding the billing of your claim. Your signature is needed so that we may file your insurance claim. While we make every effort to get tests pre-authorized, this does not guarantee payment of your claim from your insurance company.

I understand that the above practice will submit my claim for physician interpretation of my sleep study. I authorize direct payment of any applicable insurance benefits to *Pulmonary and Critical Care Specialists of Northern Virginia, P.C.* for services rendered by them directly or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance, not including contractual fee schedule reduction amounts. Balances not paid within 30 days of the statement date are subject to a $20.00 late payment fee. Should collections action become necessary, I agree to pay all collection related costs of thirty-three (33%) of the balance due, or $50.00, whichever is greater.

_____ _____

Patient Signature **Date**

_____

Printed Name (Please Print Legibly)

Rev. 12/2009

Who is the physician ordering the Sleep Study? _____

Demographic Information

Patient's name: _____ Date of Birth: _____
Last First MI

Home Address: _____
Street City State Zip Code

Home Phone: (____)_____ Work Phone: (____)_____

Social Security #: _____ EMAIL ADDRESS: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Life Partner

Place of Employment: _____ Occupation: _____

Sex: _____ Age: _____ Height: _____ Weight: _____lbs.

In case of an emergency, please contact: _____
Name Relationship Phone #

Insurance Information

Policy Holder/Guarantor Information (if different from the patient):

Name: _____ Social Security #: _____
Relationship to patient: _____Date of Birth: _____
Place of Employment: _____

Primary Insurance: _____ Phone #: _____

Policy/Member #: _____ Group #: _____

Claims Address: _____

Name of Policy Holder: _____Relationship: _____

Secondary Insurance: _____ Phone #: _____

Policy/Member #: _____ Group #: _____

Claims Address: _____

Name of Policy Holder: _____ Relationship: _____