

**THE PEDIATRIC LUNG CENTER**  
***FNA-Division of Pulmonology***

2730-A Prosperity Avenue  
Fairfax, VA 22031

19450 Deerfield Avenue, Suite 400  
Leesburg, VA 20176

P (703) 289-1410 | F (703) 289-1420

**Patient's Name:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_

**Financial Responsibility Statement**

I, \_\_\_\_\_, the undersigned, certify that I (and/or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to The Pediatric Lung Center all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize The Pediatric Lung Center to release any medical information necessary to process these claims. In consideration of health care services rendered or to be rendered by The Pediatric Lung Center to the patient, I hereby guarantee payment to The Pediatric Lung Center on demand of all charges for services and incidentals provided on behalf of the patient. I understand that I am financially responsible for charges not covered by my insurance company, including deductibles, co-insurance and non-covered services. In the event of nonpayment *for any reason*, I guarantee payment of all costs of collections, including reasonable attorney's fees. If I do not have insurance, or prefer to pay privately, I understand that payments are due in full at time of service. This Financial Responsibility Statement is valid until revoked in writing.

If you are awaiting Medicaid approval, please provide your Medicaid worker's name, phone number and date the Medicaid application was completed below. Please be aware that you will be required to pay a \$25 deposit for your visit and each visit made to The Pediatric Lung Center while your Medicaid application is pending or until approved.

For Patients with Medicaid Pending, please provide the following information:		
_____	_____	_____
Case Worker's Name	Case Worker's Phone Number	Medicaid Application Completion Date

Your signature below indicates approval of the financial responsibilities above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

**Front Desk Staff:** please provide a copy of this document to the individual signing the form.