FNA
Fairfax Neonatal Associates, P.C.
a Neonatal & Pediatric Subspecialty Group

Fairfax Neonatal Associates
Pediatric Lung and Allergy Center 703.289.1410
Pediatric Surgical Group 703.560.2236
Pediatric and Adolescent Sleep Center 703.226.2290

Patient's Name: _____ **Patient's Date of Birth:** _____

Financial Responsibility Statement

I, _____, the undersigned, certify that I (and/or my dependent) have
(Write in your name above)

insurance coverage with _____ and assign directly to Fairfax Neonatal Associates, PC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Fairfax Neonatal Associates, PC to release any medical information necessary to process these claims. In consideration of health care services rendered or to be rendered by Fairfax Neonatal Associates, PC to the patient, I hereby guarantee payment Fairfax Neonatal Associates, PC 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 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

I understand Fairfax Neonatal Associates, PC reserves the right to charge a late cancellation (less than 24 hours' notice) or no-show fee of $50.00 to patients/families for missed scheduled clinic appointments, $150.00 for a missed food challenge and $250.00 for missed scheduled sleep studies. In addition, after three (3) consecutive missed appointments or (3) missed appointments in a two year period, without notification; FNA reserves the right not to reschedule the patient for an appointment pursuant to VA Administrative Code 18VAC85-20-28.

Your signature below indicates approval of the financial responsibilities above.

Signature: _____ Print Name: _____ Date: _____

Witness Signature: _____ Print Name: _____ Date: _____