



**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