Wendy R. Gottlieb, M.D., P.L.C
1800 Town Center Drive
Suite 418
Reston, VA 20190

Financial Responsibility Form

I hereby agree to be financially responsible for any medical care and services provided in this practice to myself or other: _____.

I understand that payment will be due at time services are rendered unless other arrangements have been made. I understand that I have separate financial responsibility for any ancillary services requested by this office, such as laboratory, pathology, or x-ray testing, and that these outside tests are not covered under routine office fees. In addition, financial responsibility to this office does not cover other services such as physical therapy, hospitalization, and specialist visits.

INSURANCE: I understand that having health insurance is no guarantee that it will cover the services rendered in this office. Non-coverage may be due to deductibles not yet met, lack of coverage for that service, expired coverage, having insurance with which I do not yet participate, etc. I will be financially responsible for any provided services not covered by my insurance for whatever reason. We will submit a bill for payment on your behalf to any insurance company with which we participate. If payment has not been received within 60 days you will be responsible for payment for those services (and you would be reimbursed if payment was received in the future).

MEDICARE: We accept Medicare assignment. We will bill Medicare for you, and then subsequently bill you the 20% copayment of the accepted amount if you have no coinsurance or if your coinsurance does not pay this amount. Signing below acknowledges that some services are not covered benefits under Medicare. Your signature below signifies that you agree to reimburse this practice for any non-covered services. We are generally expected by Medicare to have you sign an "Advance Beneficiary Notice" ahead of time if we suspect that such a service may not be covered, and we will attempt to do this whenever possible. Signing below also authorizes us to "accept assignment", meaning that Medicare sends us payment directly for services rendered on your behalf.

Signature of Patient or Patient's Guardian _____Date:_____

Printed name: _____MR#:_____

Patient's name, if different.* _____

* In the case of a non-parent guardian or medical power of attorney, please provide us with copies of all relevant documents. Thank you.