MARCI KROP COOK M.D., F.A.C.O.G.
Reproductive Endocrinology/Infertility/Gynecology Specialist
1800 Town Center Drive # 313 Reston, VA 20190 TELEPHONE (703) 925-9300

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT NAME FIRST MIDDLE LAST			DATE OF BIRTH	AGE
HOME ADDRESS	CITY		STATE	ZIP CODE
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS S ☐ M ☐ SEX	HOME PHONE	
EMPLOYER	ADDRESS		WORK PHONE	
SPOUSE (or Parent) NAME	SPOUSE (or Parent) EMPLOYER		SPOUSE (or Parent) WORK PHONE	
SPOUSE (or Parent) address				
NEAREST RELATIVE/FRIEND	RELATIONSHIP	HOME PHONE	WORK PHONE	
RELATIVE/FRIENDS ADDRESS				
REFERRING PHYSICIAN/PERSON	ADDRESS		TELEPHONE	
PRIMARY PHYSICIAN	ADDRESS		TELEPHONE	
GYNECOLOGIST	ADDRESS		TELEPHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Payment is due at time of services rendered. Payment is accepted in the form of cash, check or money order.
Regardless of insurance situation, I understand that I am responsible for any balance due. If this balance due is not paid in a timely fashion, I understand I will be responsible for the balance due and any collection and/or attorney fees that are incurred in an attempt to collect this debt.

SIGNATURE (Adult or guardian if minor)_____

BILLING AND INSURANCE INFORMATION

SEND BILL TO			
FIRST NAME LAST NAME			RELATIONSHIP TO PATIENT
ADDRESS	CITY		STATE/ZIP CODE
EMPLOYER	WORK PHONE		HOME PHONE
PRIMARY INSURANCE			
INSURANCE COMPANY NAME	ID OR POLICY NUMBER		GROUP/CODE NUMBER
INSURANCE COMPANY ADDRESS	SUBSCRIBERS SOCIAL SECURITY NO.		DATE EFFECTIVE
SUBSCRIBERS NAME	HOME PHONE		RELATIONSHIP TO PATIENT
SUBSCRIBERS ADDRESS	WORK PHONE		SUBSCRIBERS DATE OF BIRTH
SECONDARY INSURANCE			
INSURANCE COMPANY NAME	ID OR POLICY NUMBER		GROUP/CODE NUMBER
INSURANCE COMPANY ADDRESS	SUBSCRIBERS SOCIAL SECURITY NO.		DATE EFFECTIVE
SUBSCRIBERS NAME	HOME PHONE		RELATIONSHIP TO PATIENT
SUBSCRIBERS ADDRESS	WORK PHONE		SUBSCRIBERS DATE OF BIRTH

PATIENT AUTHORIZATION

I,_____, hereby authorize Marci Krop Cook, M.D., F.A.C.O.G., to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to the above named provider.
I claim that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any other related claim, to the above named billing agent, (or in the case of Medicaid part B benefits, to the Social Security Administration and Health Care Financing Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above named carrier at any time in writing. I request that payment of authorized medigap benefits be made to me or on my behalf to the above named provider for any service furnished to me by the physician's supplier. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits paid for related services.

Account Number

_____ _____

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

CELL PHONE_____