Michelle van Duinen, APRN, PLLC
Psychiatric Mental Health Nurse Practitioner-BC
107 Wilcox Road – Suite 105 Stonington, CT o6378
Phone- 860-245-5811 **Fax-**860-245-4752

PATIENT INFORMATION AND INSURANCE

Name ____ Date of Birth__________

Address____

____

Phone (H) ________________ (C)_________________ (W)_________________

Email____

Social Security Number _______________

Number to call in case of office closure / provider out______________________

Marital Status ___ Single ___ Married ___ Divorced ___ Separated

Employer Name_____________________________________

Employer Address__________________________ Position___________________

Pharmacy Name___________________________ Phone Number______________

Pharmacy Address_________________________

Primary Care Name_________________________ Phone Number______________

Primary Care Address____

INSURANCE INFORMATION

PRIMARY Insurance Company ____

Identification Number____

Policy Holder's Name________________________ Date of Birth______________

Policy Holder's Social Security Number____________________

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Relationship to Policy Holder_____________________________

SECONDARY Insurance Company_______________________________________

Identification Number____

Policy Holder's Name_______________________ **Date of Birth**_____________

Policy Holder's Social Security Number____________________

Relationship to Policy Holder_____________________________

EMERGENCY CONTACT INFORMATION

Notify in case of emergency: Name_______________________________________

Relationship_______________________________ **Phone Number**_____________

I hereby authorize Michelle van Duinen APRN, PLLC to release to my insurance company or its representative, any Medical and / or Psychiatric records as well as any other information needed to obtain authorization for treatment or payment to process claims for medical benefits.

I also authorize and request my insurance company to pay directly to Michelle van Duinen APRN, PLLC the amount due ne in my pending claim for any services that has been provided.

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I hereby agree to pay any and all charges that are not covered by insurances, for any charges due to a missed appointment (no call -no show) and / or cancellation of appointment with less than 24-hour notice. The fee of $125 will be billed directly to you.

SIGNATURE **DATE**