Quality Care Medicine, LLC

Vero Beach, Florida
772-907-5935-phone
772-217-2761-fax

I, _____ at (facility name) _____

I'm requested to be seen by Willy Martezian, ARNP-C for any acute and or chronic medical/physical issues.

Signing this form is also stating all medical insurance information provided is correct. I'm responsible for any unpaid balance from the insurance company. I agree to update Quality Care Medicine immediately with any insurance and/or demographic change.

_**X**_____

Family/**Power of Attorney** of Resident- Signature

Address: _____

_____

Cell Phone #: _____

Please provide e-mail & cell # if you would like access to patient portal

E-mail: _____

*** If you have Power of Attorney please forward us a copy.

Medicare Insurance ID #_____

Secondary Insur Name: _____ ID # _____