

Quality Care Medicine, LLC

Vero Beach, Florida
772-907-5935-phone
772-408-9304-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 # _____