genoa healthcare®

Consumer Enrollment Form

Section 1. Consumer Information

Consumer Name _____
Last *First* *M.I.*

Social Sec. # _____ Date of Birth _____ Sex: M / F

Mailing Address _____
Street *City* *State* *Zip*

Shipping Address _____
Street *City* *State* *Zip*

Email Address _____ Phone _____

Section 2. Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknoweldge receipt of the *Notice of Privacy Practices* of Genoa Healthcare, LLC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practice* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at http://www.genoahealthcare.com or contacting Genoa at 1-888-GENOARX (1-888-436-6279).

I acknowledge receipt of the Notice of Privacy Practices of Genoa Healthcare, LLC.

Name (printed): _____ Signature: _____ Date: _____

For Genoa Healthcare® Employee Use Only: Inability to Obtain Acknowledgement

Please document your efforts to obtain acknowledgment and the reason it was not obtained.

□ Notice of Privacy Practices given – Consumer unable to sign
□ Notice of Privacy Practices given – Consumer declined to sign
□ Notice of Privacy Practices and Acknowledgment mailed to consumer:
  ○ Date 1st attempt: _____ ○ Date 2nd attempt: _____

Other reason consumer did not sign: _____

Employee Name _____ Date _____

Employee Signature _____ Site Location _____

Section 3. Brief Medical History

Diagnosis/Medical Conditions, please describe: _____

Medication Allergies: Y / N If yes, please describe: _____

Current Medications: _____

Section 4. Prescription Packaging

Packaging Preference: Vial - Child Resistant Y / N 30-Day Card: Y / N Dispill: Y / N

Other: Y / N _____

Section 5. Consent to Communication

By providing my telephone number to Genoa Healthcare on this Consumer Enrollment Form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from Genoa Healthcare and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. By providing my e-mail address on this form, I agree to receive e-mail messages from Genoa Healthcare and its affiliates. To stop receiving e-mails at any time, I may click “unsubscribe” at the bottom of the e-mail. Genoa Healthcare may send my PHI to me, by text message or email, in an unencrypted manner. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

*Certain restrictions apply on certain medications, please consult with the Pharmacist to see if you qualify.
**Genoa Healthcare will not share any information obtained and will not use it for any other purpose but for the Refill Reminder Program.

I understand and acknowledge that I am personally responsible for the charges at this site and that Genoa Healthcare will bill my insurance as a courtesy. In the event of non-payment, I understand that I will be responsible for any outstanding balance.

Consumer/Responsible Party Signature _____ Date _____