genoa healthcare

**Consumer Enrollment Form (v2)**

## Section 1. Consumer/Facility Information

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

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

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

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

Email Address _____ Phone _____

Facility Name (if applicable) University of New Hampshire

## Section 2. Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge 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).

_____ *(INITIAL)* I acknowledge receipt of the Notice of Privacy Practices of Genoa Healthcare, LLC.

## Section 3. Brief Medical History

Diagnosis/Medical Conditions, please describe: _____

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

Current Medications: _____

Current Pharmacy: _____

## Section 4. Prescription Packaging and Delivery Method

*Packaging Preference*: *Vial – NON-Child Resistant* Y / N | *30-Day Card*: Y / N | *Genoa Care Packaging:* Y / N | *Other:*_____

____ *(INITIAL)* Medication is required to be dispensed with child resistant safety caps to prevent children from accidental ingestion. You may elect non-child resistant packaging. By selecting "Y" for any of the prescription packaging and initialing, you are requesting and acknowledge that your prescriptions will be dispensed in non-child resistant packaging, until such time that you revoke authorization

_____ (INITIAL) *Preferred delivery method (check one):* ☐ Pick up at pharmacy ☒ Mailed ☐ Delivery Driver

## Section 5. Consent to Communication

By providing my telephone number to Genoa Healthcare on this Consumer Enrollment Form, I agree to receive automated calls and /or prerecorded messages related to my health care from Genoa Healthcare and its affiliates. I may revoke or withdraw this consent at any time. 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 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 medication services provided by Genoa Healthcare.

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

*If completing on behalf of a consumer*
**Authorized Representative Name (printed): _____**
**Signature:_____ Date:_____**
**Relationship:_____**