

**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) \_\_\_\_\_

**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, 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 Name (printed):** \_\_\_\_\_  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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