genoa
a QoL healthcare company

Consumer Enrollment Form

Section 1. Consumer Information

Consumer Name ____________ (Last) ____________ (First) ____ (M.I.)

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

Mailing Address ____________ City ____ State ____ Zip ____

Shipping Address ____________ City ____ State ____ Zip ____

Email Address ____________ Phone ____________

Section 2. Insurance Information

Payee/Billing Information - please provide a copy of Insurance Card

Billing Address ____________ City ____ State ____ Zip ____

Primary Insurance Information

Policy Holder Name ____________ (Last) ____________ (First) ____ (M.I.)

Social Sec. # ____________ Date of Birth ____________ Relationship ____________

Insurance Company ____________ Policy/Group# ____________

Secondary Insurance Information

Policy Holder Name ____________ (Last) ____________ (First) ____ (M.I.)

Social Sec. # ____________ Date of Birth ____________ Relationship ____________

Insurance Company ____________ Policy/Group# ____________

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 for Camp Merry Heart will always be Multi-Dose packaging

Section 5. Refill Reminder Program

Genoa, a QoL Healthcare Pharmacy, in order to provide prompt and convenient service to all of our consumers and to better assist our consumers with their medication therapy, has the ability to contact a consumer, guardian, or caregiver by phone when a prescription refill is due. With your consent, we can then fill the prescription and have it ready for pickup, or we can mail the prescription out to you at no extra charge.* This service is on a voluntary basis.**

I would like to enroll in the program: Y / N Text Refill Reminders Y/N

*Certain restriction apply on certain medications, please consult with the Pharmacist to see if you qualify.

**Genoa, a QoL Healthcare Company 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, a QoL Healthcare Company 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**