



Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

## Patient Consent to Treat and Authorizations Form

I acknowledge and understand that in receiving medical care with Genevive, that I authorize and consent to the administration and performance of treatments and tests which may be ordered by the physician/nurse practitioner and/or their designated assistants, only if there has been communication during which I have been given an opportunity to fully discuss the suggested treatments and tests, and my agreement is documented.

### Assignment of Benefits: Payment Agreement/Advanced Notice of Beneficiary Non-Coverage

In consideration of these medical services, I hereby assign, transfer, and set over to Genevive all my rights, title, and interest to medical reimbursement benefits under my insurance policy as provided to them. I agree to provide a **photocopy of insurance card(s)**. I authorize payment of medical benefits to Genevive and I acknowledge I am responsible for paying fees associated with the services provided if my insurance does not fully cover these services. In the event I request services not covered, I will receive an Advanced Notice of Beneficiary Non-Coverage for the anticipated fee(s) from Genevive.

### Statement of Financial Policy

I understand that payment of my bill is part of my treatment and care. Genevive will bill my insurance company for my primary care visit and any associated charges. My cooperation of payment with co-pays and charges is greatly appreciated, and Genevive is available to answer any associated insurance questions. I will receive a monthly statement for any remaining balance including but not limited to co-pays, co-insurance, and deductible amounts. I understand that my account must be paid in full each month.

Our providers may complete medical visits in person, via telehealth, or via phone. These services are all billable and by signing this form I am consenting to all visit types. Please check the appropriate box below if you wish to opt out of a certain visit type.

Telehealth Visit (audio-visual)  Telephone Consultation (audio only)

### Notice of Privacy Practices

I acknowledge that I have received and been presented with the opportunity to review the Genevive Notice of Privacy Practices.

### Minnesota Health Records Act: Genevive may disclose my health care information as follows:

1. For a Medical Emergency when Genevive is unable to obtain my consent due to a condition or the nature of the Medical Emergency;
2. To other health care providers within Related Health Care Entities when necessary for my current treatment;
3. To a health care facility licensed by Minnesota Statutes chapter 144, Minnesota Statutes chapter 144A, or to the same types of health care facilities licensed by chapter 144 and chapter 144A that are licensed in another state under certain circumstances;
4. When the disclosure is specifically authorized by law;
5. When the disclosure is to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data; and
6. When Genevive is releasing a deceased's health care records to another provider for the purposes of diagnosing or treating the deceased patient's surviving adult child.

### Authorization and Consent to Additional Limited Disclosures:

By signing this form, I authorize Genevive to disclose my health information in the following limited ways:

1. **Electronic Prescribing (E-Prescribing) Release:** I hereby provide informed consent for Genevive to use an electronic prescribing system to e-prescribe my prescriptions and view my medication history, including medication history from other healthcare providers, and/or third-party pharmacy benefit payers, for treatment purposes.
2. **Treatment:** Genevive may release my information to another physician, health care professional, or hospital to provide, coordinate, and manage my care and treatment.
3. **Payment:** Genevive may release my information for billing my insurance company or a third-party for the treatment and services that I received. For example, Genevive may provide my information to my health plan so that it can pay.
4. Genevive or reimburse me for my treatment; or to obtain prior authorization from my health plan to determine whether my plan will cover the treatment, or for purposes of an independent review of a denied claim.
5. **Health Care Operations:** To ensure Genevive is performing at high quality standards, Genevive may use and disclose my information related to quality improvement programs and data analytic purposes. This includes but is not limited to, using my information to review the treatment and services provided, as well as evaluating the performance of staff and

health care professionals. I understand that all disclosed information will be safeguarded and not rediscovered unless specifically permitted by law.

6. **Business Associates:** Genevive may disclose my information to Business Associates for Genevive to perform the contracted roles such as sending patient satisfaction surveys, and/or performing patient chart audits for evaluating performance and measuring quality standards. I understand that to protect the information that is disclosed each business associate is required to sign an agreement requiring it to safeguard the information and not rediscover the information unless specifically permitted by law.

**Authorization to Leave Message/Test Results:**

In completing and signing this form, I authorize that Genevive may leave a message containing medical information as follows:

On my home voicemail/answering machine: Yes  No  Home Phone Number: \_\_\_\_\_

On my cell phone voicemail: Yes  No  Cell Phone Number: \_\_\_\_\_

In the space below, if so desired, please indicate any family member, friend, or individual you would like to allow Genevive to disclose your health information to: \_\_\_\_\_

**Consent to Email Communication**

I understand that electronic mail (email) can be a useful tool and can supplement communication. However, email has limitations that I acknowledge, including potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Email addresses will not be shared with others outside of Genevive and will be used only for communication related to case. The email provided will not be used for marketing purposes.

First and Last Name of Authorized Person	Relationship to Patient	Email Address

Or,  I DO NOT choose to use email communication with Genevive.

**Appointment Reminders, Billing, Communications, and Method of Sending Health Information to Me:**

I authorize Genevive to send information regarding appointments, billing, and my health and treatment information via the following means: Mobile phone confirmation (standard data/text message rates would apply), text message to my mobile phone (standard data/text message rates would apply), home phone confirmation, and/or email confirmation, unless specified below.

Please check the appropriate box below if you choose to OPT OUT of a certain notification type.

Mobile Phone (standard rates would apply)       Text Message (standard data/text message rates would apply)  
 Home Phone       Email Confirmation

**Consent to Photograph:**

Photographs may be taken with a Genevive owned camera/device for identification, assessment, and treatment. I understand that the photographic image will be stored in my confidential electronic record and will not be shared/released outside of Genevive without further expressed written consent from myself and/or legal representative.

**Revocation:**

I understand that this consent will continue indefinitely unless I cancel it in writing to: Genevive Health Information Management, 3433 Broadway Street NE., Suite 300, Minneapolis, MN 55413. The cancellation will take effect when Genevive receives my written notice. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.

**Attestation:**

If I have concerns with this consent form, I will discuss them with Genevive Admissions Department. I understand that Genevive will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form, my failure to sign will not impact my treatment. However, I acknowledge that I may not be able to get insurance payment for my care.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

(\*Include a copy of Durable Power of Attorney paperwork)



## New Patient Information Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  Declined to Answer  
 Gender Identification:  Male  Female  Transgender Male; F to M  Transgender Female; M to F  Other  Declined to Answer  
 Marital Status:  Never Married  Married  Widowed  Divorced  Other: \_\_\_\_\_  
 Race:  African  Asian  Caucasian  Native American  Native Hawaiian  Other \_\_\_\_\_  
 Ethnicity:  non-Hispanic  Hispanic  declined Country of Origin: \_\_\_\_\_  
 Primary Language:  English  Other: \_\_\_\_\_ Interpreter Needed:  Yes  No  
 Social Security # \_\_\_\_\_ Religion: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Level of Living:  Assisted Living  Memory Care  Hearth  
 Patient Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Name of Power of Attorney: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Email Address (provide if you agree to the use of email communication): \_\_\_\_\_

**\*Please note a copy of Durable Power of Attorney (POA) paperwork is required (if applicable)**

### EMERGENCY CONTACT INFORMATION

Primary Contact: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Secondary: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Email Address (provide if you consent to the use of email communication): \_\_\_\_\_

### INSURANCE INFORMATION

Primary Payer:  Medicare  Insurance  Private Pay  Other \_\_\_\_\_  
 Medicare #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Medicaid #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

### Insurance Company

Insurance Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_

### **Secondary Insurance Company (If Applicable)**

Insurance Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_

### **Send Billing Correspondence To:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_



## Authorization for Release of Information

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**I authorize and request the release of my healthcare information FROM:**

Clinic or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

**I authorize and request the release of my healthcare information TO:**

GENEVIVE

3433 BROADWAY STREET NE, STE. 300, MINNEAPOLIS, MN 55413

Phone: (763) 587-7737 Fax: (763) 587-7069

**These are the records I would like to release:** Date(s) treatment was received: \_\_\_\_\_

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Clinic Visit Notes (2 years) | <input type="checkbox"/> Consultation Reports                   | <input type="checkbox"/> Radiology Reports (recent) |
| <input type="checkbox"/> Most recent H&P              | <input type="checkbox"/> Discharge Summary Lab Reports (recent) | <input type="checkbox"/> Immunization Record        |
| <input type="checkbox"/> Other: _____                 | <input type="checkbox"/> Psychological Testing/Reports          | <input type="checkbox"/> Hospital Reports           |

\*Exclude the following information from the records released:

- |   |   |
|---|---|
| <input type="checkbox"/> Drug/Alcohol abuse/treatment & diagnosis | <input type="checkbox"/> Mental illness, Psychiatric evaluation/treatment |
| <input type="checkbox"/> HIV/AIDS diagnosis/treatment/testing     | <input type="checkbox"/> Sexually transmitted disease                     |

**Purpose of Release:**

- |  |                                    |                                |   |
|--|------------------------------------|--------------------------------|---|
| <input type="checkbox"/> Continuing/Transfer of Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal | <input type="checkbox"/> Personal Use (fees are applied for records beyond 2 years) |
| <input type="checkbox"/> Other _____                 |                                    |                                |   |

**This Authorization expires on the following date, event, or condition:** \_\_\_\_\_

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Genevive receives my notice in writing. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.

**Statement of Authorization:**

I hereby authorize Genevive, to disclose medical information concerning the above-named patient to the party identified in the "From" section above. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV related information unless I specifically exclude above. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, or payment, or my eligibility for benefits.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If other than patient, please state relation:** \_\_\_\_\_

This authorization complies with HIPAA Privacy Rule. A photocopy or fax of this authorization shall have the same effect as the original signature.