Genao's Medical Supply
PH. (732) 324-8700 | Fax: (732) 324-8702
471 New Brunswick Ave Perth Amboy, NJ 08861
1010 Clifton Ave. Ste 103 Clifton, NJ 07013

Patient Intake Form

Patient Information

Name/Nombre:	Date of Birth/Fecha de Nacimiento: / /
Insurance/Seguro:	Member ID/ID del Miembro:
Height/Altura: Weight/Peso:	Gender/Genero: ( ) M / Hombre ( ) F / Mujer
Cellphone/Movil:	Home Phone/Tel. Casa:
Emergency Cont./ Cont. de Emergencia:	Phone Number/Telefono:

Address/Direccion:		
City/Cuidad:	State/Estado:	Zip/Codigo Postal:
Email/ Correo Electronico:		

Primary Doctor/Doctor Primario:	
Phone Number/Telefono:	

PATIENT AGREEMENT

By signing below, I authorize **Genao's Medical Supply** to obtain, use, and disclose my protected health information (PHI) and medical records as necessary for prior authorizations, medical necessity reviews, billing, claims, appeals, audits, and related insurance matters. I accept the **Assignment of Benefits (AOB)**, authorizing Genao's Medical Supply to bill my insurance directly and receive payment for supplies and services provided. I understand I am responsible for any applicable deductibles, co-payments, or co-insurance. I agree to remit to Genao's Medical Supply any insurance payments issued directly to me for these services.
I appoint **Genao's Medical Supply** as my authorized representative to act on my behalf with my health plan, Medicare, Medicaid, and/or any Managed Care Organization, including for medical necessity reviews, prior authorizations, claims, appeals, grievances, and related communications. I authorize contact via SMS, email, and/or automated telephone calls regarding my care, supplies, and insurance matters. I acknowledge that Medicare Supplier Standards, HIPAA Notice, and Patient Bill of Rights & Responsibilities are available at **www.genaodme.com**.

ACUERDO DEL PACIENTE

Al firmar, autorizo a **Genao's Medical Supply** a usar y compartir mi información médica cuando sea necesario para autorizaciones, facturación, reclamaciones, apelaciones y otros asuntos con mi seguro. Acepto la **Asignación de Beneficios**, lo que permite a **Genao's Medical Supply** facturar directamente a mi seguro y recibir el pago por los productos y servicios brindados. Entiendo que soy responsable de cualquier deducible, copago o coseguro. Si el seguro me envía un pago directamente, acepto entregarlo a **Genao's Medical Supply**. Autorizo a **Genao's Medical Supply** a comunicarse con mi plan de salud, Medicare, Medicaid u otras aseguradoras en mi nombre. Acepto ser contactado(a) por **mensaje de texto (SMS), correo electrónico o llamadas telefónicas** sobre mi atención, suministros y asuntos del seguro. Reconozco que los documentos requeridos están disponibles en **www.genaodme.com**.

Print Name/Nombre:_____

Signature/Firma:_____ Date/Fecha:_____

Relationship/Relation (if guardian): ☐ Parent/Padre ☐ Legal Guardian/Tutor Legal ☐ Other/Otro: _____