



GeneCare[®]
Medical Genetics Center

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CONSENT FOR TREATMENT AND PAYMENT WAIVER FORM

All of the following information pertaining to the patient's visit must be completed.

Patient Name: _____

Medical Record Number: _____ Date of Service: _____

Name of Health Insurer: _____

Referring Physician / Practice: _____ /North Texas Perinatal Associates

Treatment / Procedure: Genetic Counseling and / or Laboratory Services

I have been advised the procedure(s) listed above are provided at the request of my obstetrician. These services are separate from the services being provided by North Texas Perinatal Associates. I understand I will be billed separately for these services by Genecare Medical Genetics Center. I also understand some or all of the services listed above may not be reimbursable under my plan. I am, also, responsible for all referrals, pre-certifications, lack of authorizations, out of network liabilities or if a plan determines a visit / procedure is not "medically necessary". I agree to remit payment in full or according to any pre-established payment plans to Genecare Medical Genetics Center no later than 30 days from Date of Service.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____