Greenwood Genetic Center

GENETIC SERVICES CONSENT FORM

Individual's Name _____ Date of Birth _____ SSN _____

Name of DDSN Board or Private Provider _____ Case Manager/Early Interventionist – Phone # _____

The South Carolina Department of Disabilities and Special Needs (DDSN) and the Greenwood Genetic Center work together to serve individuals and families who have developmental delay, intellectual disability, learning disabilities, autism, and birth defects. A genetic evaluation is one of the services offered by DDSN. The purpose of this evaluation is to attempt to find the cause of an individual's learning problems and/or birth defects. For more information about genetic services, please read *The Genetic Evaluation: A Guide for Families and Individuals.*

There is no direct cost or billing to DDSN individuals or their families for genetic services provided by the Greenwood Genetic Center. The Greenwood Genetic Center will bill private insurance, Medicaid, or Medicare for genetic services when applicable.

Given the above information, I, _____
(print service recipient or parent/guardian's legal name), hereby indicate by my signature below that I:

☐ Accept genetic services for the above named individual. I understand that I can, at any time, choose to revoke my consent to genetic services. **By accepting genetic services, I authorize the release of any records to the Greenwood Genetic Center deemed necessary to provide ongoing genetic services**. **A copy of this form is as valid as the original.**

☐ Decline further genetic services at this time. Declining genetic services does not affect other services provided by DDSN.

BENEFITS ASSIGNMENT

I hereby authorize Greenwood Genetic Center to furnish information to my insurance carrier(s) concerning me (or that of my dependent), for the purpose of payment for services. I hereby assign to the Greenwood Genetic Center all payments for medical services rendered to me or my dependent. A copy of this assignment can be used in lieu of the original.

_____ _____
Individual's Signature Date

_____ _____
Parent/Legal Guardian's Signature & Relationship Date

_____ _____
Printed Name of Above Signature Daytime Phone

_____ _____
Mailing Address Evening Phone

_____ ____ _____
City State Zip

_____ _____
Witness Date

Charleston Office
3520 W. Montague Ave., Suite 104
North Charleston, SC 29418
Ph: 843-746-1001
Toll free: 1-866-588-4363
Fax: 843-746-1002

Columbia Office
1911 Thurmond Mall
Columbia, SC 29201
Ph: 803-799-5390
Toll free: 1-800-679-5390
Fax: 803-799-5391

Florence Office
101 South Ravenel St., Ste 370
Florence, SC 29506
Ph: 843-664-2983
Fax: 843-468-2099

Greenville Office
14 Edgewood Dr.
Greenville, SC 29605
Ph: 864-250-7944
Toll free: 1-866-478-4363
Fax: 864-250-9582

Greenwood Office
106 Gregor Mendel Cir.
Greenwood, SC 29646
Ph: 864-941-8100
Toll free: 1-888-442-4363
Fax: 864-941-8114

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