

Agreement to Receive Chronic Care Management Services

As a patient with two or more chronic conditions, you may benefit from a new program providing chronic care management services to Medicare patients. Chronic care management services include:

- Care management for chronic conditions, including systematic assessment of your health care needs, timely scheduling of preventive care services, and medication review and oversight;
- Access to your care team 24-hours-a-day, 7-days-a-week, including non-face-to-face access such as telephone, email, and secure messages;
- Successive routine appointments with a designated member of your care team;
- Creation of a comprehensive plan of care for your health issues;
- Management of care transitions among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visits, and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities;
- Coordination with home and community based clinical service providers

Your Rights

- As part of the chronic care management services, you can request a copy of your comprehensive plan of care.
- You have the right to stop these chronic care management services at any time, effective at the end of the calendar month. Please contact our practice to opt out. *

You agree and consent to the following by signing this agreement:

- Patient You consent to _____ providing chronic care management services to you and billing for them.
- You acknowledge that only one provider can furnish and bill for chronic care management services for you during a calendar month. Please let us know if you have entered into a similar agreement with another practice.
- You consent to electronic communication of your health information with others involved in your care.
- **You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, whether or not you had a face-to-face meeting with your provider.**

Patient's First Name *

Patient's Last Name *

Patient or Guardian/Caregiver Signature *

I understand this is a legal representation of my signature o documents, including legally binding contracts - just the same as pen and paper

Name of Guardian or Caregiver (if applicable)