Chronic Care Management Patient Agreement

The services provided by the Chronic Care Management Program are:  
 ● 24 hour access to the care team  
 ● priority access to the provider for urgent appointments  
 ● organized review and scheduling of all preventative care  
 ● medication review and oversight  
 ● creation of a personalized care plan to assure care is provided in a way that fits my choices   
 and values

A Care Coordinator, Registered Nurse, who will follow you for multiple (two or more) chronic conditions expected to last at least 12 months and put you at risk for acute exacerbation, decompensation, or functional decline.

Communication will include: accompanying you to provider appointments, telephone access, secure messaging through your portal, internet or other non-face-to-face consultation methods.

I understand that my medical record may be shared via electronic communication.

I understand that I may have to pay a co-insurance approximately \_\_\_ per month (as a Medicare beneficiary), or the amount determined by my insurance plan (non Medicare, Medicaid plans.) I may have to pay the deductible if I have not already met my insurance’s plan deductible amount. My provider will bill for this service monthly.

I have the right to stop the care coordination by contacting my Care Coordinator or primary care provider. I understand that only one provider at a time can provide these services to me. The cancellation will take effect the following month.

I hereby consent to the above services, and understand by following the above recommendation; I   
 am actively taking part in managing my chronic disease.

I decline Care Coordination Services.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider/Designee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_

Care Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_