Chronic Care Management (CCM) Patient Consent Form

Patient Name: _______________________________ Date of Birth: _______________

Medicare Number: ____________________________

1. Explanation of Services

Chronic Care Management (CCM) is a program designed to provide comprehensive care for patients with two or more chronic conditions. The services included in this program are:

- Regular check-ins with your healthcare team (at least 20 minutes per month)
- Development and maintenance of a comprehensive care plan
- Coordination of care with other healthcare providers
- 24/7 access to a healthcare professional for urgent care needs
- Medication management and reconciliation
- Patient education and support for self-management

The goal of CCM is to improve your overall health outcomes and quality of life by providing ongoing, coordinated care for your chronic conditions.

2. Patient Consent

By signing this form, I, _______________________________ (patient name), agree to participate in the Chronic Care Management program offered by _______________________________ (healthcare provider/organization name). I understand the nature of the services provided and agree to the ongoing management of my chronic conditions through this program.

3. Privacy and Confidentiality

I understand that my personal health information will be used and shared as part of the CCM program. This information will be handled in compliance with HIPAA (Health Insurance Portability and Accountability Act) regulations. I have been provided with a copy of the practice's Notice of Privacy Practices.

4. Cost and Billing Information

I understand that CCM services may involve costs such as copayments or coinsurance. These services will be billed to Medicare or my insurance provider. I acknowledge that I am responsible for any portion of the cost not covered by my insurance.

Medicare will be billed $___________ per month for CCM services.

My estimated monthly out-of-pocket cost is $___________.

Only one healthcare provider can bill for CCM services for me in a given calendar month.

5. Patient Responsibilities

As a participant in the CCM program, I agree to:

- Actively participate in developing and following my care plan
- Attend scheduled appointments and respond to check-in calls
- Provide accurate and up-to-date health information
- Inform my healthcare team of any changes in my health status or medications
- Follow the agreed-upon treatment plans and self-management strategies

6. Revocation of Consent

I understand that I have the right to withdraw my consent and discontinue participation in the CCM program at any time. To do so, I must inform _______________________________ (healthcare provider/organization name) in writing. Withdrawing from the program will not affect my ability to receive other services from this healthcare provider.

Authorization

By signing below, I confirm that I have read and understood this consent form. I voluntarily agree to participate in the Chronic Care Management program and authorize ___________________________________ (healthcare provider/organization name) to provide CCM services and bill Medicare and/or other insurance providers for these services.

Patient Signature: ________________________________ Date: ________________

Healthcare Provider Signature: ______________________ Date: ________________

______________________________ **(Healthcare Provider/Organization Name)**

______________________________ **(Address)**

______________________________ **(Phone Number)**