

#### **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.

Website: https://vitalhealthservice.com/

Phone: (928)377-4684



### 2. Patient Consent

By signing this form, I,	(patient name),
agree to participate in the Chronic Car	
	(healthcare provider/organization name).
understand the nature of the services	provided and agree to the ongoing
management of my chronic conditions	s through this program.
3. Privacy and Confidentiality	L
of the CCM program. This information	information will be used and shared as part will be handled in compliance with HIPAA ountability Act) regulations. I have been Notice of Privacy Practices.
4. Cost and Billing Information	<u>on</u>
	nvolve costs such as copayments or led to Medicare or my insurance provider. It any portion of the cost not covered by my
Medicare will be billed \$	per month for CCM services.

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

My estimated monthly out-of-pocket cost is \$\_\_\_\_\_\_.

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month.

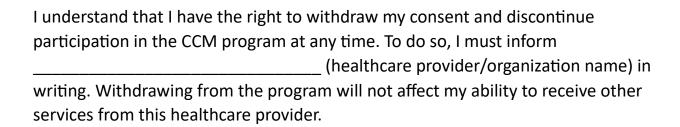


#### **5. Patient Responsibilities**

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**



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### **Authorization**

, , ,	t I have read and understood this consent form. I in the Chronic Care Management program and (healthcare
	provide CCM services and bill Medicare and/or
Patient Signature:	Date:
Healthcare Provider Signature:	Date:
	(Healthcare Provider/Organization Name) (Address)
	(Phone Number)

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