



www.amscardiology.com 215.517.1000

CCM - Chronic Care Management Patient Consent Form

A message from your doctor:

Your health is very important to my staff and me. Our goals are to:

- Keep you as healthy as possible
- Provide you with the best care
- Keep you at home and, if possible, out of the hospital
- Minimize the costs and inconvenience of unnecessary visits to doctors, labs, or urgent care facilities

I encourage you to participate in the Chronic Care Management (CCM) program. Chronic Care Management (CCM) services help manage your health between office visits. The program provides a series of non-face-to-face activities and additional services especially for our CCM patients.

For example, you will have a dedicated Care Team that is familiar with your conditions. We actively help you manage all your medications. We help coordinate your care with your other doctors. We share your health information only with other authorized providers.

Your Care Plan includes valuable information that will help you understand your medical conditions. Your Care Plan will help you to be as healthy as possible. Your caregivers and other authorized providers can access your Care Plan 24/7 using our secure medical portal in the event you require care when we are not available.

Your insurance covers CCM services, and you may have a co-pay or deductible. Each month, after we provide you with a minimum of 20 minutes of non-face-to-face services, we will bill your insurer(s). Either you or your supplementary insurer will be responsible for any deductible or co-pay.

You may stop this service at any time, for any reason. If you choose to stop the service, we will provide it only through the last day of the calendar month of your decision. Your signature is required to end Chronic Care Management services, so please ask my staff for the CCM revocation form.

You can only give CCM consent to one provider at a time. If another physician has offered to provide CCM, you will have to choose which physician is best able to treat and manage all your conditions. Please let my staff or me know if you change your mind, or if you have any questions. Signing this Chronic Care Management - Patient Consent Form allows me to begin immediately providing you with CCM services.

I agree to participate in the Chronic Care Management program. Yes _____ No _____

Patient Signature

Date Signed

Printed Patient Name

Date of Birth

**Copy must be given to Patient and retained by Provider*