

CHRONIC CARE MANAGEMENT (CCM)

CONSENT TO PARTICIPATE

I _____ agree to participate in **the Chronic Care Management (CCM) Program**. I understand that I qualify for this program because I have the following qualifying conditions.

CONDITIONS: *(to be filled in by provider)*

- 1.
- 2.
- 3.

- I understand that a Nurse Care Coordinator will be assigned to help manage the oversight of my care, and that the Care Coordinator will share their contact information with me and the provider.
- I understand that only one primary care practice can provide chronic care management.
- Care is communicated to the providers by my care team through a document called the **Plan of Care**.
- 24-hour-a-day, 7-day-a-week (24/7) access is available to this patient by contacting the patient physician's office at the following number: **(772) 678-7043**
- CCM services can be revoked at any time in person or by phone (effective at the end of the month)

I understand that cost sharing (co-insurance and deductible) applies to CCM services, and CCM services can be cancelled at any time in person or in writing. I also understand that I may be charged a fee of \$8/month.

Patient signature

Date