Sample CCM Consent Form

Date

I, Patient Name, agree to the provision of Chronic Care Management services (CCM) by my provider, Provider Name, (MD, DO, PA, NP).

I understand that these services include Continuity of Care with a member of my primary care team and:

- Access to care 24 hours per day 7 days per week and access to care for routine appointments
- Care management for chronic conditions
- Detailed review and updating of my medication list on a regular basis
- Development of a patient centered, comprehensive care plan and that I will receive a copy of that care plan
- Sharing of my care plan with other appropriate providers and staff who are helping me with my care
- Coordination with home and community based providers of my care

I authorize the electronic communication of medical information with other providers involved in my care.

I understand that I can stop CCM services at the end of any calendar month if I decide I no longer want these services. If I decide to stop these services, I will no longer receive chronic care management services. Stopping chronic care management will not have any effect on my usual primary care services.

I understand that only one provider can furnish and be paid for these services in any given calendar month and that I may be responsible for a monthly co-payment charge for these services.

I agree that the provider named above is designated as my primary care provider for providing Chronic Care Management services. This designation will be in effect until revoked by me or my caregiver.

Patient Signature