Medicare Patient Chronic Care Management Program

We would like to offer you a program at this doctor's office that will help us work together to improve your health. A lot goes on at times other than during your office visits. People on your health team work with each other and with you on the phone, on your medical record system and in person. This helps you in many ways. For example, it keeps your medicine list, tests that you need, and other services well organized. Medicare and your doctors know these help to keep you healthy.

A new Medicare program starts in 2015 to be sure that you have these four things:

1. A phone number for you to talk to a doctor or nurse at any time. 24 hours a day, 7 days a week.
2. If you use a computer, the plan offers you a way to ask your health team questions about your body like ear ache, bladder or bowel problems and more.
3. Time for you to learn from your health team how to improve your health. This can be on the phone, using your computer or in person.
4. There are many people on your health team and they need time to share your plan. Your team is led by your primary care doctor and may also include: a pharmacist, nurse, social work, dietitian, diabetes educator, behavior health therapist, health coach, athletic trainer, and/or spiritual care. It is depending on what you need.

Taking part in the Chronic Care Management Program is optional, up to you.

By signing up for the program, you agree to:

1. Make a co-payment of approximately $8-9 for each calendar month that the services above are used. The co-payment will be billed to you.
2. Sign below that you understand and allow your health team to share your electronic health record.

I agree that I have read and understand all of the above information. By signing below, I agree that I want to take part in the Chronic Care Management Program. If I had any questions they have been answered. I understand I do not have to sign this or take part in this program; it is voluntary. I also swear that I am the patient or I have authorized someone to sign for me.

I can decide at any time to stop taking part in this program and the co-pay will stop at the end of the month. The plan is for me to take part for one year unless I tell my doctor's office I want to stop.

_____ _____ _____

Name/DOB Signature Date

Email form back to: ***Vgreenflaglermedical@gmail.com*