EVMS Medical Group

AGREEMENT TO RECEIVE CHRONIC CARE MANAGEMENT SERVICES

As of January 1, 2015, Medicare (and potentially other carriers) covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a day, 7-days-a-week, including telephone access and other non-face–to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
  - Referrals to other health care providers,
  - Follow-up after I visit an emergency department,
  - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Only one physician or health care professional can be paid to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____is designated as my primary care physician for purposes of providing chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____ Date: _____

Patient or guardian signature: _____