Your clinic name, address, and logo here

Patient Consent Agreement for Chronic Care Management Services

My physician, _____ has recommended that I receive Chronic Care Management (CCM) services because I have been diagnosed with two or more chronic conditions, which are expected to last at least twelve months, and place my health at risk of decline.

I understand that CCM services include: 24/7 access to a member of my care team via phone or other non-face-face means; a designated practitioner or care team member with whom I am able to get successive routine appointments; systematic assessment of my health care needs; processes to ensure timely receipt of preventative care services; oversight of my medication regimen; a jointly created and comprehensive care plan that is congruent with my choices and values; management of care transitions across all of my providers and settings; coordination with home and community based clinical service providers.

By signing this agreement, I consent to receive these services and agree to the following:

- My provider has explained to me the availability and the elements of the CCM services that are relevant for my condition(s).
- I consent to receive CCM services from the provider listed above and/or any associates he/she may designate to assist in providing me with CCM services.
- I understand that I have the right to stop CCM services at any time (effective at the end of a calendar month) with this provider and the effect of a revocation of this agreement. I may revoke this agreement verbally by calling _____ or in writing to _____. After revocation of this agreement, I may opt to receive CCM services from another healthcare provider in the month following revocation of this agreement.
- I understand that Medicare permits only one practitioner to furnish and be paid for these services during a calendar month.
- I understand that I will receive a written or electronic copy of my comprehensive care plan.
- I authorize electronic communication of my medical information with other treating providers.
- My provider has explained to me any potential cost-sharing obligations that may apply when receiving CCM services.

Patient Name	Date of Birth
Patient Signature	Date

This template does not constitute legal advice. Please consult your legal counsel.