

THIRD COAST FAMILY PRACTICE (TCFP)

CARE MANAGEMENT PROGRAM

Consent to Participate

I, _____ have agreed to participate in TCFP's Care Management Program to obtain better control of my chronic conditions. I understand I will work closely with the TCFP Nurse Care Manager who will collaborate and share information with Dr. Matheson and any other health care professional(s) involved in managing my care.

Care Management is a covered benefit by Medicare, Priority Health, Blue Cross Blue Shield and some other insurances. I understand that I can participate in only ONE care management program at a time, and by signing this consent I am choosing to participate with the TCFP Care Management Program until such time that I dis-enroll in writing utilizing the bottom of this consent form. I also understand that I am responsible for any patient portion of my care such as copay/ co-insurance/ or deductible.

Signed:

_____	_____	_____	_____	_____	_____
Patient	Date	RN Care Manager	Date	Dr. Matheson	Date

Please dis-enroll me from the Care Management Program. I understand my request will be effective 30 days from the date of this request.

_____	_____	_____	_____
Patient	Date	RN Care Manager	Date