Chronic Care Management Consent Form

PATIENT NAME _____ MD NAME _____
EMERGENCY CONTACT _____ INSURANCE TYPE _____

By signing this agreement, I understand and agree to the following terms:

- I have been notified at an in-person provider visit, within the last 12 months visit that I qualify for and received education about CCM services from my healthcare provider.
- I can only consent to CCM services by one provider per month. If I choose to consent to CCM from another provider, I will withdraw from this service prior.
- With CCM my health care provider will provide me with clinical education, changes in my medication prescription and/or my plan of care, as needed on a monthly basis.
- My monthly interactions are non face-to-face, and may be with other clinical staff supervised and overseen by my medical provider.
- *I can receive 24/7 access to care as outlined by my provider*.
- My healthcare provider and their clinical staff will have access to my personal health information through the iUGO Care platform.
- I will receive a copy of my care plan in writing or electronically.
- I authorize electronic communication of my health information with other treating providers as part of coordination of my care.
- I authorize the release of my medical information by my healthcare provider to authorized representatives of Medicaid, Medicare, or other insurance carriers for determining benefits.
- I authorize my healthcare provider to disclose my necessary health information to other vendors whose services may be required in conjunction with the CCM program.
- As applicable Medicare, Medicaid or other health insurance benefits for CCM will be applied for this service. There may be a copay with CCM services, and I may be billed for a portion
- If I lose capacity to consent, an authorized person must receive informed consent on my behalf to continue receiving CCM services.
- I have the right to withdraw from CCM services at any time.

I, _____(Print your name) have read and understood the information and consent to participate in the Chronic Care Management program as stated above.

Date: _____
(dd/mm/yyyy)

_____ _____
Signature of Patient or Authorized Person Relationship of Authorized Person