

CCM CONSENT FORM

I, _____, agree to the provision of Chronic Care Management (CCM) services by my provider, Jessica Adkins, M.D.

CCM services are available to patients with two or more chronic conditions. Chronic conditions are conditions that are expected to last at least 12 months and require ongoing medical attention or limit activities or daily living or both.

I understand these services include Continuity of Care with a member of my primary care team and:

- Access to care 24 hour per day 7 days per week and access to care for routine appointments
- Care management for chronic conditions
- Detail review and updating of my medication list on a regular basis
- Development of a patient centered, comprehensive care plan and that I will receive a copy of that care plan
- Sharing my care plan with other appropriate providers, specialists, and staff who are helping me with my care

I authorize electronic communication of medical information with other providers involved with my care.

I understand that I can stop CCM services at the end of any calendar month if I decide I no longer want these services. If I decide to stop these services, I will no longer receive CCM services. Stopping CCM will not have any effect on my usual primary care services.

I understand that only one practitioner at a time can provide CCM, I will contact the office if I receive services from another provider during that calendar month.

I agree that the provider named above is designated as my primary care provide for providing CCM. This designation will be in effect until revoked by me or my caregiver.

Patient or Patient Representative Signature: _____

Date: _____

Printed Name of Representative: _____