**Main Street Medical Group**

**Chronic Care Management Program**

Dear Patient,

You have been selected for a new program from Medicare that provides some really great services to help you manage your chronic conditions. This program is available to Medicare patients with 2 or more Chronic Conditions. Your doctor believes that this program could really help to manage your Chronic Conditions.

Here are the benefits of the program:

* We’ll created a Care Plan that is custom-designed to meet your goals. (you’ll receive a copy)
* We’ll do a full assessment of your health needs.
* Every month, we’ll check in to make sure things are going well.
* You’ll have access to a healthcare provider who can address your chronic conditions 24/7.
* Hopefully we’ll be able to address any issues outside of the office, resulting in fewer office visits and fewer hospital admissions.

**Before we start, we need you to consent to the following:**

* We may share your information with your other providers and this may be done electronically. This will allow all those involved with your care to stay up-to-date with your progress in this program.
* Only one provider can provide this service to you during a 30-day period.
* You agree that **Main Street Medical Group** will be that one provider.
* You can cancel or revoke this service at any time by talking to our staff. We'll provide you a form to sign if you decide to cancel.
* Depending on your insurance, you may be billed for a small portion of the CCM Service. In many cases, the service is free without a Copay. In some cases, there is an $8 / month Copay. We’ll let you know which applies to you. In the long term, this service should help to reduce your overall healthcare costs and will save money in the long term.

**Please sign here to enroll in the program!**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone # for me to be reached at: (\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Optional): Legal Rep or Power of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*