ADC Chronic Care Management Consent Form

I agree to allow _____ to provide me with Chronic Care Management (CCM) services and to be designated my CCM provider. I also understand that other physicians may from time to time provide CCM services to me under this consent.

I understand that these services will include:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible
- Reviewing my medications and any questions that I have
- Help with scheduling office visits and tests that my doctor ordered
- Receiving a plan of care with personal health goals
- Sharing of my care plan with other doctors that I see and the staff who are helping with my care
- Working closely with home health and other healthcare resources in my area

I understand that other doctors that I see will receive my medical information electronically through a computer system.

I understand that only one doctor can provide CCM services for me each month and that I may have to pay a monthly co-payment charge.

I understand that I can stop CCM services at the end of any month by contacting the doctor's office through telephone or the patient portal. If I decide to stop these services, I understand that I will no longer receive chronic care management from this doctor's office but this will not have any effect on my usual primary care services.

Patient or guardian signature _____

Printed name _____Date _____

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THE AUSTIN DIAGNOSTIC CLINIC