Healthy Horizons Clinic

Chronic Care Management Consent Form

Your provider recommends you join a Chronic Care Management program.

Healthy Horizons Clinic is proud to offer a new program called Chronic Care Management (CCM) to better support our elderly patients and those enrolled in Medicare or Medicare Advantage plans. This program is designed for individuals diagnosed with two or more chronic conditions expected to last at least 12 months and that place their health at risk of worsening.

Enrolling can help you manage your chronic conditions.

We recognize that staying on top of appointments, medications, and care coordination can be difficult. We also understand that at times it has been hard to reach our clinic or get timely medication refills. With CCM, we're offering enhanced access and more personalized care.

- Help with routine appointments and referrals
- Medication management and regular health assessments
- Be available 24/7 to answer questions and assist you
- Schedule your routine appointments and manage other medical referrals
- Creation of a personalized care plan based on your goals and needs
- Help connect you with other resources that can help you stay healthy

Let's get started coordinating your care!

By signing below you are enrolling in CCM and agreeing to the following:

- Only one provider can furnish CCM Services to you during a calendar month
- My medical information may be shared with other healthcare providers involved in my care.
- I authorize Healthy Horizons Clinic to access my Protected Health Information (PHI) in order to provide me effective CCM services
- I will receive a written or electronic copy of my care plan.
- Depending on supplemental coverage and your primary insurance, you may be billed a standard copay (20% / $9 per month). This covers all CCM Care Coordination support and does not include a face-to-face meeting with the provider
- You may stop CCM services at any time, effective at the end of the calendar month, by notifying Healthy Horizons Clinic directly

Signature of Participant (or Legal Representative)

Check one: ☐ I Accept ☐ I Decline

Partcipant First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Phone Number: (_____)_____

Provider First Name: _____ Provider Last Name: _____

Authority of Legal Representative: ___Self ___Power of Attorney ___ Parent of Minor ___ Other (please specify)

Legal Representative Name (if applicable): _____

Signature: _____ Date: _____