HARDER family practice P.A.

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AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician and HFP staff is willing to provide such services to me, including the following:

- The ability to get successive, routine appointments.
- Care management of my chronic conditions, including timely scheduling of all recommended preventative care services, medication reconciliation, and oversight of my medication management.
- Management of my care as I move between and among health care providers and settings, including the following:
    - Referrals to other health care providers
    - Follow-up after I visit an emergency department
    - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility)
- Coordination with home and community-based providers of clinical services.
- 24/7 patient access for urgent needs.

I understand that as part of these services I will receive the following:

- Management of chronic conditions
- Management of referrals to other providers
- Management of prescriptions
- Ongoing review of patient status

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

My signature authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____

Patient or guardian signature: _____

Date: _____