CHRONIC CARE MANAGEMENT (CCM)
Enrollment Informed Consent

What is Chronic Care Management (CCM)?

Chronic Care Management (CCM) are services by a physician or non-physician practitioner (Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only practitioner can bill CCM per service period (month).

- Use of a Certified Electric Health Record (EHR)
- Continuity of Care with Designated Care Team Member
- Comprehensive Care Management and Care Planning
- Transitional Care Management
- Coordination with Home- and Community-Based Clinical Service Providers
- 24/7 Access to Address Urgent Needs
- Enhanced Communication (for example, email, or patient portal)
- Advanced Consent

Have you, the patient or the acting health care agent, read the literature on CCM, and agree to participate in CCM services, and understand the following:

- There may be a possible copay (Refer to your insurance card for copay information)
- Patient can cancel the CCM program at any time
- Patient's Care Plan may be shared with other providers
- Only one practitioner per month can bill for the CCM service

Failure to enroll in CCM services prevents the Sequoia Practitioners from managing chronic conditions "in-house," therein leading to a greater chance of requiring out-of-facility appointments with specialists for appropriate management.

☐ **If Medicaid is your primary insurance, CCM services are an uncovered benefit. Please check this box to opt-out.**

Patient Name	DOB
Signature of Patient	Date
Signature of Legal Representative / Relationship	Date

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