2018 MEDICARE CHRONIC CARE MANAGEMENT PATIENT CONSENT FORM

_____I AGREE TO BE ENROLLED IN THE MEDICARE CHRONIC CARE MANAGEMENT PROGRAM, TO BE MANAGED BY MY PRIMARY PHYSICIAN OF INTERNAL MEDICINE OF SOUTHWEST FLORIDA. I UNDERSTAND THAT I CAN REVOKE THIS CONSENT AT ANY TIME.

----------I DO NOT WISH TO PARTICIPATE IN THE CCM PROGRAM

----------I HAVE SELECTED DESIGNATED ANOTHER PHYSICIAN AS MY CCM PROVIDER, AND I UNDERSTAND THAT BY SO DOING, THAT PHYSICIAN WILL BE PROVIDING ALL MEDICATION REFILLS, PRIOR AUTHORIZATIONS OR MEDICINES AND OTHER SERVICES, ELECTRONIC COMMUNCATIONS BETWEEN OTHER PROVIDERS, MANAGING ANY HOME HEALTH CARE I MAY NEED, AND PROVIDING AND/OR MONITORING MY PREVENTIVE MEDICAL CARE. (IF THIS APPLIES TO YOU, PLEASE PROVIDE US WITH THE NAME OF YOUR CCM PROVIDER:_____)

SIGNATURE:_____

DATE:_____