Patient Name _____

Date of Birth: _____

Family Medicine of Michigan
Consent for Care Management Services

Date of Referral: _____

Date of Consent: _____

I, the above named patient understand that my healthcare provider is offering Advanced Primary Care Management (APCM) and Care Mangement (CCM) services to help manage my chronic conditions. I agree to receive these services, which may include regular check-ins, care coordination with other providers, medication reviews, and proactive outreach to address my health needs. I understand that I can stop receiving APCM/CCM services at any time, and that only one provider can bill for these services per month. I have been informed about the potential costs associated with APCM/CCM services and agree to any applicable co-pays. By signing below, I consent to the provision of APCM/CCM services.

☐ We would like to offer you a program at FMOM that will help us work together to improve your health. A lot goes on at times other than during your office visits. People on your health team work with each other and with you on the phone, on your medical record system and in person. This helps you in many ways. For example it keeps your medicine list, tests that you need, and other services well organized. Your insurance company and your doctors know these help to keep you healthy.

☐ Taking part in this Care Management Program is optional. By agreeing to participate, you understand that there will possibly be out of pocket expenses such as copayment, deductible, co-insurances and the like. We make every effort to check that you have benefits for this service, but cannot quote to you exactly how your plan will process the claims. Medicare patients can expect (after deductible) a monthly charge ranging from ($3 to $30).

☐ The plan is for this program to last until my health care provider and I feel that I have obtained the goals set forth to improve my health care. However, I understand that I can decide at any time to stop taking part in this program by notifying my care coordinator.

☐ *Verbal Consent given on* _____

☐ *Patient Signature* _____