Nevada Heart & Vascular

Patient Name: _____ DOB:_____ Patient ID#:_____
(Please Print)

Primary Care Dr: _____ Phone Number: _____

Dear Patient,

As a patient with two or more chronic conditions, (_____), (_____), you may benefit from a program that **Nevada Heart & Vascular** is offering all Medicare patients. Our goal is to make sure you get the best possible care from everyone who is involved in your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. Within this, we will need your consent to participate for one year.

Your assigned clinician of your care is _____. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree to do the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we will continue to comply with all laws related to the privacy and security of your health information.
- We will bill Medicare for this Chronic Care Management for you once per month. The fee for this service allowed by Medicare is about $41.82, of which your portion will be 20% (most secondary insurances cover this amount). Although you may or may not come into the office every month, your account will reflect this change and you will be responsible for the payment. Our office will have a record of our time spent managing your care if ever you have a question about what we did each month.
- Only **one** physician can bill this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and your conditions. Please let your physician or staff know if you have entered into a similar agreement with another physician/office.

You have a right to:

- A comprehensive care plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue this service at any time, for any reason. Because your signature is required to end your chronic care management services, please ask our staff members for the CCM form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management Program. Yes____ No____

_____ _____
Patient Signature Date