

Nevada Heart & Vascular Center

CHRONIC CARE MANAGEMENT AGREEMENT

Patient Name: _____ DOB: _____ Patient ID#: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address: _____ Primary Care Dr: _____

Dear Patient,

As a patient with two or more chronic conditions, you may benefit from a program that **Nevada Heart & Vascular Center (NHVC)** offers all Medicare patients. NHVC'S goal is to make sure you receive the best possible healthcare by coordinating your healthcare with your other physicians, laboratory and radiology facilities, and by reducing emergency room visits and hospital stays. This will minimize doctors' visits and overall medical expenses.

NHVC will talk to you on the phone about your symptoms; help you with the management of your medications; and will provide you with a copy of the comprehensive care plan. Medicare allows NHVC to bill for these services during any month services have been provided for at least 20 minutes of non-face-to-face care for you and your conditions which may include a telephone call where your care and conditions are reviewed.

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

You agree to the following:

As needed, NHVC will share your health information electronically with others involved in your care. Please rest assured that NHVC will continue to comply with all laws related to the privacy and security of your health information. NHVC will bill Medicare for the Chronic Care Management service provided for you once per month. The fee for this service allowed by Medicare is \$63.15. Your 20% co-pay is \$12.63 per month. Most secondary insurances cover the \$12.63 per month. It is your responsibility to verify with your secondary insurance to see if this service is covered and paid. Medicare may apply the \$63.15 to your deductible if you have not met your yearly deductible. Any balance not paid by your insurance will be your responsibility.

NHVC will record the time spent managing your care if ever you have a question about what services were provided each month.

Only **one** physician can bill for this service for you each month. Therefore, if one of your other physician(s) has offered to provide you with Chronic Care Management services, you will have to choose which physician is best able to treat you and your conditions. Please let your NHVC physician or NHVC staff know if you have entered into a similar agreement with another physician/office.

You have a right to:

A comprehensive care plan from NHVC that will help you understand how to care for your conditions so that you can be as healthy as possible. You can discontinue this service at any time, for any reason. Because your signature is required to end your Chronic Care Management services, please ask a NHVC staff members for the Chronic Care Management disenrollment form.

Nevada Heart & Vascular Center understands your time and your health is valuable and we hope that you will consider participation in the program with Nevada Heart & Vascular Center.

I agree to participate in the Chronic Care Management Program. Yes _____ No _____

Patient Signature

Date

Physician Signature

Date