Avante
Physician Services

Agreement to Receive Chronic Care Management Services

As a patient with two or more chronic health conditions, you may benefit from a care management program our health center offers to Medicare patients. The service are available through our chronic care management program which include:

- Assisting you manage your ongoing health conditions, checking in with you on your health care needs, making appointments for preventive care, and helping you understand your medications.
- Making sure you can get in touch with your provider or care team 24-hours-a-day, 7-days-a-week via the nursing staff at the building.
- Working with you to make a plan for how to best care for your health care needs.
- Helping you work with and coordinate care across different providers and settings, including specialists or other providers, hospitals, and the emergency department.

Your Rights

As part of the chronic care management services, you will receive a copy of your care plan at your request.
You have the right to stop chronic care management services at any time (effective the end of a calendar month). Please contact Avante to stop your consent.

You agree and consent to the following by signing this agreement:

You consent to **AVANTE PHYSICIAN SERVICES** providing chronic care management services to you.
You agree to allow AVANTE PHYSICIAN SERVICES to bill Medicare for these services during any month that provide at least 20 minutes of chronic care management services to you.
You are aware that only one provider or hospital can provide and bill for chronic care management services for you during a calendar month. Please let us know if you receive these services from any other provider during any month.
You agree to allow AVANTE PHYSICIAN SERVICES to share your care information electronically with other providers delivering care to you.

You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, even if there is aface-to-face meeting with your provider.

Patient Name: _____ DOB: _____

Signature: _____

Date: _____

Power of Attorney/ Legal Guardian (if applicable):

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