Chronic Care Management Consent Form

I agree to allow BARBARA A. LUBIN, MD to provide me with Chronic Care Management (CCM) services and to be designated my CCM provider.
I understand that these services will include:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible
- Reviewing my medications and any questions that I have
- Help with scheduling office visits and tests that my doctor ordered
- Receiving a plan of care with personal health goals
- Sharing of my care plan with other doctors that I see and the staff who are helping with my care
- Working closely with home health and other healthcare resources in my area
- Barbara A. Lubin, MD or member of her care team will be accessible 24/7 for your urgent chronic care needs

I understand that other doctors that I see will receive my medical information

I understand that only one doctor can provide CCM services for me each month and that I have to pay a monthly co-payment charge. (The co-payment will be billed to you).

I understand that I can stop CCM services at the end of any month by contacting the office. If I decide to stop these services, I understand that I will no longer receive chronic care management and may continue my customary medical care with Barbara A. Lubin, MD

A copay/deductible may apply during the month in which the service is provided.

I agree that I have read and understand all of the above information. I allow Barbara A. Lubin, MD LLC to bill my insurance for chronic care management services. By signing below, I agree that I want to take part in the Chronic Care Management Program. If I had any questions, they have been answered.

I understand I do not have to sign this or take part in this program; it is voluntary.

Patient or guardian signature _____

Printed name _____Date _____