Patient Information Sheet

Name: _____ _____ _____ _____ _____ _____
FIRST MIDDLE LAST SUFFIX NICKNAME DATE OF BIRTH

Patient Demographics

Address: _____
STREET

_____
CITY, STATE, ZIP CODE

_____
COUNTRY

Gender: ☐ Male ☐ Female

Home Phone: _____

Daytime Phone: _____

Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnic Group

☐ Declined to state
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race

☐ African American or Black
☐ American Indian or Alaska Native
☐ Asian
☐ Declined to state
☐ Middle-Eastern
☐ Native Hawaiian/Other Pacific
☐ Other Race
☐ Pacific Islander
☐ White or Caucasian

Guarantor

☐ Same as Patient *(if same as Patient, do not complete)*

Name: _____
FIRST , MIDDLE , LAST

Social Sec. # _____

Address: _____
STREET

_____
CITY, STATE, ZIP CODE

Patient Email

_____

Patient Employer

Name: _____

Address: _____
STREET

_____
CITY, STATE , ZIP CODE

Emergency Contact

Name: _____

Phone _____

Language

_____

Insurance Primary

Company: _____ Address: _____

Insured's Employer: _____ Address: _____

Insured's Name: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

DOB: _____ Gender: ☐ Male ☐ Female Phone: _____

Policy Group ID: _____ Individual ID: _____ Copay: _____

Insurance Secondary

Company: _____ Address: _____

Insured's Employer: _____ Address: _____

Insured's Name: _____ Patient Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

DOB: _____ Gender: ☐ Male ☐ Female Phone: _____

Policy Group ID: _____ Individual ID: _____ Copay: _____

Rx

Local Pharmacy: _____ Mail Order Pharmacy: _____

How did you hear about CoreLife? ☐ Family/Friend ☐ Internet ☐ CL Website ☐ Facebook ☐ Print Ad ☐ Insurer Info ☐ Hospital Referral ☐ Physician Referral ☐ Other: _____

RELEASE: I assign payment to and authorize CoreLife, Inc to file a claim with my insurance for payment of services or to accept assignment of any government benefits due to me. I authorize the release of all information necessary to process these claims. I understand that if it is later determined that I am not eligible to receive benefits for these services, I will personally be responsible for payment to CoreLife, Inc. Photocopies of this form are valid.

_____ _____
Signature of Patient or Responsible Party if Minor Date

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____

Who in your family has had the following

Heart disease/Heart Attack/Congestive Heart Failure_____
Cancer (list type) _____
High Cholesterol _____
Sudden Death _____
Diabetes or borderline diabetes _____
Mental illness (depression, bipolar, etc.)_____
Who in family struggles with weight_____
Hypothyroidism _____
Stroke _____
High Blood Pressure _____
Other medical condition _____

Please circle if you have been having any of the following symptoms

- ☐ Weakness
- ☐ Coarse hair
- ☐ Emotional
- ☐ instability
- ☐ Slow movement
- ☐ Loss of hair
- ☐ Thick tongue
- ☐ Hoarseness
- ☐ Slow Speech
- ☐ Gain in weight
- ☐ Heart Palpitations
- ☐ Swollen Feet
- ☐ Excessive/painful menses
- ☐ Constipation
- ☐ Nervousness
- ☐ Diminished sweating
- ☐ Swelling of face/eyelids
- ☐ Tired/fatigue
- ☐ Difficulty breathing
- ☐ Poor Memory
- ☐ Brittle Nails
- ☐ Dry, Coarse Skin
- ☐ Pale Skin
- ☐ Depression
- ☐ Coldness and cold skin
- ☐ Headaches

Please check the medical conditions YOU have been diagnosed with in the past or currently

- ☐ Past or current drug or alcohol problems
- ☐ Depression or anxiety
- ☐ Diabetes: Type 1(juvenile) or 2(adult)
- ☐ Gestational Diabetes
- ☐ Insulin Resistance/Prediabetes/BorderlineDiabetes
- ☐ Polycystic Ovarian Syndrome
- ☐ Heart Burn
- ☐ Glaucoma (Open or Narrow Angle)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack/Heart Failur
- ☐ Arrhythmia
- ☐ Heart Valve Problems/ Heart Murmur
- ☐ Do you have a pacemaker: ☐ or ☐
- ☐ Do you have a defibrillator: ☐ or ☐
- ☐ History of passing out (syncope)
- ☐ Asthma or other Lung diseases (Type: _____)
- ☐ ADHD (Attention deficit disorder)
- ☐ Bipolarism or other psychiatric conditions (Explain: _____)
- ☐ Kidney Disease (Type: _____)
- ☐ Liver Disease (Type: _____)
- ☐ Obstructive sleep apnea (use a CPAP)
- ☐ Insomnia/ other sleep disorders
- ☐ Thyroid Disorders (Low or High or Other: _____
- ☐ Other Chronic Medical Conditions: _____
- ☐ Do you have any known Drug allergies? If yes please explain:_____

Financial Policy
CoreLife, Inc

Thank you for choosing **CoreLife, Inc** ("CLI") as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. ***Patients are responsible for understanding their health insurance coverage(s) and benefits.*** There may be limitations and exclusions to coverage. ***You are responsible for any charges not covered by your plan.***

Insurance Accounts: We ask that you present your insurance card at **every visit.** If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date of service** a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. ***Self-pay patients are responsible for paying 100% of charges at the time services are rendered.***

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third party liability information **within 30 days of the date of service** may result in any unpaid balances transferring to patient responsibility. ***Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.***

Financial Policy
CoreLife, Inc

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care by CLI. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash, check or money orders are also acceptable methods of payment. If your check is dishonored (returned for non-sufficient funds) you will be required to pay an additional fee of $35.00.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. **Your failure to appear for a scheduled appointment or to cancel an appointment at least 12 hours prior to the visit will result in a missed appointment fee of $35**. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

By signing bellow, I fully understand and agree to the terms of the CoreLife Financial Policy.

Signature: _____ Date: _____

Waiver & Release of Liability

Name: _____ Phone: _____

Mailing Address: _____

Street City Zip

For and in consideration of the opportunity to participate in a the CoreLife Lifestyle Weight Loss Program, and for other valuable consideration, the receipt and sufficiency of which is hereby acknowledged, for and on behalf of myself and my personal representatives, family, heirs, successors, assigns and next of kin, I,_____ , do hereby fully and forever waive, release, discharge and covenant not to sue CoreLife, Inc.., its successors, assigns, parents, subsidiaries, affiliates, owners, employees, representatives, officers, agents, contractors and directors (each considered one of the "Releasees" hereunder) from any and all liability, actions, causes of action, suits, proceedings, controversies, damages, judgments, executions, claims and demands whatsoever, in law, equity or otherwise, that may arise and that may be caused or alleged to be caused, in whole or in part, by the negligence or intentional conduct of one or more of the Releasees or otherwise, including, but not limited to, any claim of personal injury, medical complications, allergic reactions, death, property damage or failure to achieve my desired health benefits. I intend this Waiver and Release of Liability to be effective whether or not any accident, loss, damage, injury or death results from the negligence or intentional misconduct of one or more of the Releasees.

I agree that if, despite this Waiver and Release of Liability, I, or anyone on my behalf including, but not limited to, my personal representatives, family, heirs, successors, assigns and/or next of kin, makes a claim or claims against any or all of the Releasees, I will indemnify and hold the Releasees (or any one of them) harmless from any and all litigation expenses, attorney fees, claims, judgments, losses, liabilities, damages or costs which may be incurred by the Releasees (or any one of them) as a result of and/or in association with such claim or claims.

I have read and I voluntarily sign this Waiver and Release of Liability Agreement. I fully understand its terms, I understand that I have given up substantial rights by signing it and I have signed it freely and without any inducement or assurance of any nature and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law. I agree that if any portion of this agreement is held to be invalid or unenforceable, the remainder shall continue in full force and effect to the maximum extent allowable by law. This Waiver and Release of Liability has no expiration date.

Signature: _____ Date: _____

Signature of Parent/Guardian –signature required if participant is 17 years old or younger:

Name: _____ Phone:_____

Mailing Address: _____

Street City Zip

Notice of Privacy Practices

Effective date: May 1, 2012

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447.

Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447.

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447.

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Practice Administrator at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 at 410-975-5447

I have received a copy of the CoreLife Notice of Privacy Practices.

Signature: _____ Date: _____

HIPAA DISCLOSURE FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy and offered the opportunity to read the medical practice's Notice of Privacy Practices. This notice provides information about how CoreLife medical practice may use or disclose my private and protected health information.

_____ _____

Signature of patient or legal representative Date

_____

If other than patient, indicate relationship

CoreLife medical practice has made a good faith effort to obtain the above acknowledgement. At this time the following circumstances exist:

____ Patient refused to sign

____ The patient is not able to sign and there is no legal representative available

_____ _____

CoreLife Authorized Signature

NOTICE TO OUR PATIENTS

Prescription drugs may be purchased at CoreLife by the patient if a pharmacy is not conveniently available to the patient. The determination of "conveniently available" is made solely by the patient. If your prescription is incorrectly filled or you have any questions regarding your prescription please contact the medical administrator at CoreLife at 579 Baltimore Annapolis Blvd, Severna Park, MD 21146 or call 410-975-5447.

Patient Signature: _____ Date: _____

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby give permission for: CoreLife Inc. (821 W. Benfield Rd. Suite 5, Severna Park, MD 21146)

to release my medical records, whether copies or summaries, compiled during office visits to the following

physician:_____ This release is valid for one year from today's date.

Patient Signature: _____

Date: _____

Dear Patient,

As a patient with two or more chronic conditions, you can benefit from a new program that CoreLife is now offering all patients. Our goal is to make sure you receive the best care possible from everyone that is involved in managing your health profile. We are allowed 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. You must provide your consent to participate once a year.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- We will bill for this chronic care management once a month. Although you may or may not come into the office every month, your account will reflect this charge and you may be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for 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 all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

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 any of our staff members for the CCM termination 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