AGREEMENT TO RECEIVE MEDICARE CHONIC CARE MANAGEMENT SERVICES DR. KATHRYN AMACHER

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my Care Team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face-means of communication (e.g., email)
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation and oversite of my medication management
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values
- Management of my care as I move between and among health care providers and settings include the following:
    - Referrals to other health care providers,
    - Follow-up after I visit an emergency department
    - Follow-up after I am discharged from a hospital or other facility (e.g., skilled nursing facility)
    - Coordination with the home and community-based providers of clinical services

I understand that as a part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective as the end of a calendar month) I can choose, instead to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician of health care professional to furnish my chronic care management services within a calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and insurance applied to physician services.

I herby indicate by signature on this agreement that **Dr. Amacher** is designated as my primary care physician for purposes of providing Medicare chronic care services to me and billing for them.

Signature also authorizes my primary care physician to electronically communicate my medical information with the other treating providers as part of the care coordination involved in chronic care agreement services.

Designation is effective as of the date below and remains in effect until revoked by me.

Patient Name (please print): _____ Date: _____

Patient or Guardian Signature: _____