WCRx Pharmacy Chronic Care Consent form

Dear Patient,

As a patient with two or more chronic conditions (_____), you may benefit from a new program that WCRx Pharmacy is now offering all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. WCRx Pharmacy can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; WCRx Pharmacy can talk to you on the phone about your symptoms; WCRx Pharmacy can help you with the management of your medications; and WCRx Pharmacy will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that WCRx Pharmacy has 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.

Your assigned clinician in charge of your care is a WCRx Pharmacy trained clinical staff employee. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

As needed, WCRx Pharmacy will share your health information electronically with others involved in your care. Please rest assured that WCRx Pharmacy continues to comply with all laws related to the privacy and security of your health information.

WCRx Pharmacy will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is _____, of which your portion will be no charge. Although you may or may not come into the office every month, your account will reflect this charge and you will not 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 WCRx Pharmacy 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. WCRx Pharmacy knows your time and your health is valuable and WCRx Pharmacy hopes 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

(Separate PDF Link)

WCRx Pharmacy Chronic Care Management Stop Form

As of _____, I
_____have
(Date) *(Printed Name)*
Decided to terminate participation in the Chronic Care Management program. I understand that any services provided in the future regarding any of my conditions will have to be in-person and that I will no longer be charged for the Chronic Care Management codes.

_____ _____
Patient Signature Date