NEW HORIZONS
INTERNAL MEDICINE

*Dear Patient,*_____,

As a patient with two or more chronic conditions ( ), you may benefit from a new program that, New Horizons Internal Medicine LLC 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. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us 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.

Your assigned clinician in charge of your care is Ralph A. Jackson MD .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, 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 Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is $42.00 of which your portion will be $8.00. Although you may or may not come into the office every month, your account will reflect this charge and you will 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.

I agree to participate in the Chronic Care Management program. Yes ____ No_____

_____ _____

Patient Signature Date of Birth