



Patient Name

Date of Birth

Effective Date: _____

CONSENT FOR TREATMENT

Those who elect to receive Complex Chronic Care Coordination and Management Services from Transitions Chronic Care, Inc. agree to the following:

- Complex Chronic Care Coordination and Management Services is a patient-centered approach to healthcare provided by the Transitions Chronic Care team of medical professionals.
- The goal of Complex Chronic Care Coordination and Management is to improve quality of life, decrease the need for hospitalizations, and support patients in managing their health and healthcare decisions. The Transitions Chronic Care team collaborates with the patient, family, and other involved provider(s) to develop a plan of care that addresses identified needs.
- A Doctor, Nurse Practitioner or Physician Assistant will provide an initial medical visit in the patient's home to evaluate acute and chronic care needs. This visit will be followed by regular visits and/or phone calls for the purpose of monitoring chronic conditions, managing medications, addressing ongoing or new concerns, and proposing additional interventions as indicated. This holistic model of care includes communicating and collaborating with other treating health professionals to address identified care needs.
- The Chronic Care team conducts visits Monday through Friday 9am-5pm, and provides a triage line 24 hours per day, 7 days per week to answer questions regarding current health concerns. The Complex Chronic Care Coordination program does not provide medical procedures or emergency care. In the event of an emergency, call 911.

FINANCIAL AGREEMENT

By placing initials below, you (the patient or responsible party) agree to the following:

_____ (*INITIAL*) Services provided by Transitions Chronic Care medical providers will be billed to your insurance. Your insurance may require a co-pay for the visits. If you are unable to pay the co-pay, you may be eligible for a sliding scale based on financial eligibility.

_____ (*INITIAL*) Reimbursement of authorized provider's services will be paid to Transitions Chronic Care, Inc. You authorize release of necessary information (which may include diagnoses and treatment information) to process claims for billing purposes.

ACCEPTANCE AND RELEASE OF MEDICAL INFORMATION

Private Health Information (PHI) will be made available to Transitions Chronic Care, Inc. This agreement includes requests for personal and clinical records from prior to current health care providers. You, the patient (or responsible party), consent to have your PHI used or disclosed for treatment, payment, or health care management. You have the right to revoke this consent at any time. Transitions Chronic Care, Inc. will reasonably ensure that only relevant PHI is used or disclosed to those who need the information including, but not limited to, your primary care provider and specialist(s) for the sole purpose of care coordination.

CHOICE OF HEALTH CARE PROVIDER

The Transitions Chronic Care, Inc. staff may make suggestions for hospice and/or home care on your behalf if indicated. You have the right to choose the care provider of your choice. The quality of care and services provided by the Chronic Care Team will not be affected by your choice of other healthcare providers.

PATIENT RIGHTS – PRIVACY RULE

You, the patient (or responsible party), understand you have the following rights: To access your PHI; to request amendments to your PHI as warranted; to restrict uses and disclosures of PHI; to request alternative methods of communication; and to obtain an accounting of disclosures made regarding my PHI.

Patient/Responsible Party

Date

TCC Physician or Provider

Date