Advanced Primary Care Management (APCM)
Patient Consent Form

Patient Name: _____

Date of Birth: _____

Medicare ID or SS #: _____

Clinician: _____

Date of Consent: _____

What Is Advanced Primary Care Management (APCM)?

Advanced Primary Care Management is a Medicare Part B, as well as other commercial insurance carriers, service that provides ongoing, comprehensive primary care between office visits. These services may include care coordination, medication management, care planning, communication with other providers, and support for managing chronic conditions.

What Services Are Included?

As part of APCM, the care team may:

- Coordinate care with specialists, hospitals, facilities, home health, or hospice
- Review and manage medications
- Develop and maintain a personalized care plan
- Provide care management support between visits
- Offer access to the care team for urgent needs, including after hours
- These services may be provided by the clinician and other members of the care team under the clinician's supervision.

Important Medicare Rules

- Only one provider or practice may bill Medicare for APCM services for you in a given calendar month.
- APCM services are billed monthly, even if you do not have an office visit that month.
- APCM cannot be billed in the same month as certain other Medicare care management services (such as Transitional Care Management).

Cost Sharing

- Medicare Part B generally applies a 20% coinsurance for APCM services.
- If you have supplemental insurance, it may cover this coinsurance.
- If you are a Qualified Medicare Beneficiary (QMB), you will not be charged coinsurance.

Your Rights

- Participation in APCM is voluntary.
- You may stop APCM services at any time by notifying the practice.
- Stopping APCM will not affect your ability to receive regular medical care from this practice.
- You may choose a different provider for APCM services in the future.

Patient Acknowledgment and Consent

By signing below (or providing verbal consent), I acknowledge that:

- I understand what Advanced Primary Care Management services are.
- I understand that APCM services are billed monthly to Medicare.
- I understand that coinsurance may apply.
- I understand that only one provider or practice may bill APCM services for me each month.
- I understand that I may stop APCM services at any time.
- I agree to receive Advanced Primary Care Management services from this practice.

Patient or Authorized Representative Signature: _____

Relationship (if applicable): _____

Date: _____

Witness / Staff Name: _____

Date: _____

Verbal Consent (If Applicable)

☐ Patient provided verbal consent on _____(date).

Documented by _____