Meetinghouse Family Physicians

HORIZON ONLY

CONSENT FOR HEALTHCARE PHYSICIAN TO ASSIST PATIENT IN SELECTING A PATIENT CENTERED MEDICAL HOME

By signing this form, I agree that as a Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) member, I have selected Dr. , as my Patient Centered Medical Home (PCMH), available through Horizon Healthcare Innovations, and give permission for said PCMH to notify Horizon BCBSNJ of my selection. I understand that my PCMH will give me the opportunity to receive care through a physician-led team focused on me.

By selecting a PCMH, I authorize my care team to have access to my medical information which will assist the PCMH to navigate me through the health care system and help me to take greater control of my own health and wellness.

I understand I have the right to revoke my PCMH selection at any time.

First Name: _____ Middle Name: _____

Last Name: _____

Horizon BCBSNJ Member ID#: _____

Group#: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Email: _____

Patient Signature: _____ Date: _____

Patient Representative: _____

Relationship to Patient: _____