BOARD CERTIFIED INTERNAL MEDICINE
4566 E HWY 20 STE 103
NICEVILLE, FL 32578-8831
850.897.1223 VOICE, 888.423.5018 FAX, www.bluewatermedicine.com

Dear Prospective Patient:

On behalf of my practice, I would like to thank you for considering us for your healthcare. My staff and I pride ourselves on maintaining good relationships with our patients. I appreciate your patience in waiting for your first appointment. We do limit the number of new patients so that our established patients can get the best appointment availability. **Please note that as of 2008 we are not accepting new patients who take chronic narcotic pain medicines for non-cancer pain. Before filling out any forms, please make sure we accept your insurance (if any), by reviewing the list at http://bluewatermedicine.com** Call (850) 897-1223 or email bluewatermedicine@gmail.com with any questions.

Before we schedule your appointment we ask that you please complete and turn in the attached forms along with a front and back copy of photo ID and insurance cards (we will gladly make copies for you). We will then contact you after a few days to schedule an appointment. The usual wait time for a new patient appointment is 2-4 weeks after we receive all paperwork. The usual wait time for an established patient appointment is 0-3 days. Rarely, your medical needs may not match what our office supplies. In that case we will decline to schedule an appointment, and your forms will be shredded or returned.

Patients often want to know something about my background. I have attached a summary of my qualifications. At your first visit, your insurance co-payment / cost-share will be pre-authorized on your credit or debit card.

We are located in The Courtyard Plaza at Bluewater Bay. We are on Highway 20, 0.1 miles west of the intersection of Highway 20 and the White Point Road. Courtyard Plaza is a two story brick building with a green roof between McDonalds and CVS, across the street from the Waffle House. Dr. Ponder's office is in Suite 103, on the lower floor towards the back left of the building. The building entrance is adjacent to Highway 20. If you are coming from Niceville, turn left at light onto Bluewater Blvd and then take right turn behind CVS. Our hours are Monday through Thursday 8:00 a.m. – 4:00 p.m. We close one hour for lunch.

Medicare patients only: Please see important section on Chronic Care Management.

Sincerely,

Kenneth W. Ponder, M.D.

Version 20170425

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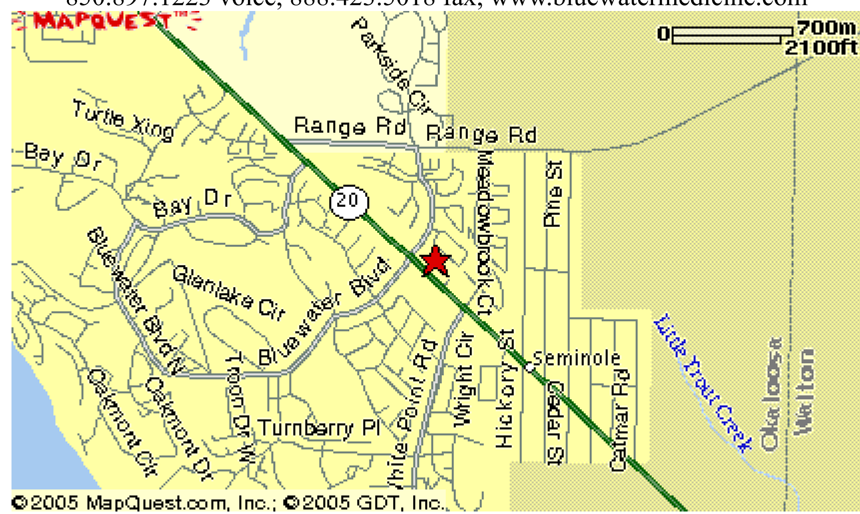


Courtyard Plaza is a two story brick building with a green roof between McDonalds and CVS Pharmacy, across the street from the Waffle House. Dr. Ponder's office is in Suite 103, on the lower floor towards the back left of the building. The building entrance is adjacent to Highway 20.

Kenneth W. Ponder, M.D.

Curriculum Vitae

4566 E Hwy 20 Ste 103 | www.bluewatermedicine.com | Married, born 1964
Niceville, FL 32578-8831 | (850) 897-1223, (888) 423-5018 fax | US Citizen

Experience

Private Practice Internal Medicine Physician - Kenneth W. Ponder, M.D., P.A. Active Staff Twin Cities Hospital August 1996-Dec. 2009. Affiliate Staff Dec. 2009-present. Secretary of Medical Staff 1999. Chief of Medical Staff 2000. Board of Trustees 2001-2006. Vice Chief of Staff 2008-2009. Niceville, Florida.
Kindred at Home – Ft Walton Beach, Florida. Medical Director. April 2017-present.
Emerald Coast Health Alliance – Ft Walton Beach, Florida. Board Member 2015-present
Twin Cities Hospital Skilled Nursing Unit – Niceville, Florida. Medical Director. July 1998-July 1999
Orlando Health Care Group - Orlando, Florida. Clinical Internal Medicine. August 1994 - August 1996.
East Coast Medical Network - Orlando, Florida. Clinicial Medicine. February 1993 - January 1995.

Licensure

State of Florida Medical License, ME 0063310
Board Certified Internal Medicine, November 1994-2024 (last re-certified 2014)
Drug Enforcement Agency Registered
CPR.
National Provider Identification Number 1124093737.

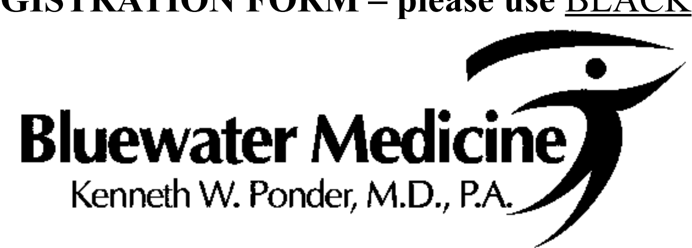
Education

Orlando Regional Healthcare System, Orlando, Florida. Internal Medicine Residency. July 1991 - June 1994 (Chief Resident, Outstanding Resident Award)
University of Alabama School of Medicine, Birmingham, Alabama. Medical Doctor. August 1987 - June 1991 (3.51 / 4.00 QPA)
University of Alabama, Tuscaloosa, Alabama. B.S. Chemical Engineering, Cum Laude, August 1982 - May 1987 (3.62 / 4.00 QPA)

Leisure

Computers, travel, family.

PATIENT REGISTRATION FORM – please use BLACK ink. v20170425



Name: ____ Birthdate:________________________
residence address: ___________________________________ Phone:___________________________
____ S.S. No.__________________________
____Email (patient or interested person:

_______________________________________ **(we notify of test results by email, please try not to leave blank)**
[ ] Check if you would like to subscribe to our email newsletter. It is brief and infrequent (1 per month on average). We do not share your email address. Cell Phone:________________

WHERE TO MAIL BILL:

Name:____
Address:____ Relationship: ____________________
__________________________:_________________________ Phone:_________________________

EMPLOYERS / MARITAL STATUS

Patient Employed by:____
Address:____ Phone: ________________________
Marital Status:_________

EMERGENCY CONTACT
(Not Living with You)

Name:____ Home Phone:___________________
Address:____ Work Phone: __________________
Relationship to You:__________________________________ Cell Phone:____________________

SPOUSE / COMPANION

Name:____ Date of Birth: __________________
Address:____ Phone: ________________________

REFERRAL SOURCE

How did you find us (check best answer) ? [ ] current patient suggestion. [ ] yellow pages. [ ] internet (what site ________________________) [ ] hospital referral line. [ ] physician suggestion
] other – please explain _______________________________.

Insurance Information: Please bring insurance cards (if any) and government issued photo ID. We will make a photocopy front and back.

We expect co-payments or non-insurance expenses at the time of service. We accept cash, checks, MasterCard, Visa, American Express and Discover Card. $25 returned check charge.

STATEMENT OF PERSONAL FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. If event of default, I agree to pay reasonable collection costs / attorney fees.

Signed:____ Date: __________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I authorize payment of medical benefits Kenneth W. Ponder, M.D., P.A. for professional services rendered. I authorize the release of any medical information necessary to process this claim or as required by law. I authorize you to contact me and/or leave messages for me on my voice mail, answering machine , e-mail , cell phone and/or text message..

Signed: ____ Date: _________________________

HEALTH INFORMATION INVENTORY

Please take a few moments to fill out the following questionnaire. **Please use** BLACK **ink.** We will use this information as part of our continual efforts to provide you with the best health care. All the information you provide will become part of your medical record and is therefore kept **strictly confidential**. Please answer these questions to the best of your ability, leaving blank those questions for which you are unsure of the answer.

NAME___________________________ DATE OF BIRTH___________________
TODAY'S DATE ___________________________________

IMMUNIZATION STATUS: Year received (most recent, give best estimate)

Influenza (flu)	[ ]
Pneumococcal pneumonia	[ ]
Hepatitis B	[ ]
Tetanus/Diphtheria	[ ]

HEALTH HABITS/SOCIAL HISTORY

		YES	NO	FORMER	If yes or former, list how often, how many years, when quit?
<	SMOKING	☐	☐	☐	__________________
<	ALCOHOL	☐	☐	☐	__________________
<	DRUGS	☐	☐	☐	__________________

Occupation:_____________________________________

Any history of possible hazardous chemical exposure:_☐ YES ☐ NO

If yes, what: _____________________________________

Are you caring for any ill family members at home? ☐ YES ☐ NO

Do you have any disability? (For example, hearing loss, glasses)LIST:

____

PAGE 2: **HEALTH INFORMATION INVENTORY**

Your name ________________ Date of Birth ____________ Today's date____________________

PREVENTIVE HEALTH MEASURES: (List any you have done; use approximate date)

EVERYONE:	DATE (of most recent)	**WOMEN:**	DATE (of most recent)
< COLON CANCER SCREENING		MAMMOGRAM	[ ]
- Stool hemoccults (blood)	[ ]	PAP SMEAR	[ ] _________
- Flexible sigmoidoscopy	[ ]	BONE DENSITY	[ ]
- Colonoscopy	[ ]	**MEN:**	
< Heart disease prevention		PROSTATE CANCER SCREENING	
- Cholesterol measured	[ ]	- PSA	[ ]
- Daily aspirin	[ ]		_________

PAGE 3: **HEALTH INFORMATION INVENTORY**

Your name _______________ Date of Birth ____________ Today's date____________________

CURRENT MEDS/DOSAGES: Include prescription, over the counter, herbs, vitamins, eye drops, nasal spray

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

(ok to say "see list"; remember to attach)
PHARMACY NAME, BRANCH, phone number: __________________________________

ALLERGIES/ADVERSE REACTIONS?

Please list any medications, foods or environmental exposures (for example, bee stings, x-ray dye) that have led to an allergic or adverse reaction (LIST reaction, for example, nausea or rash): _

PERSONAL/FAMILY HISTORY

Is there a personal or family history (mother, father, sister, brother ONLY) of any of the following diseases?

	You	Mom	Dad	Sis/Bro	Comment
AIDS/HIV	__	__	__	__	________________________
Alcoholism	__	__	__	__	________________________
Anemia	__	__	__	__	________________________
Anesthesia Complications	__	__	__	__	________________________
Anxiety	__	__	__	__	________________________
Arthritis	__	__	__	__	________________________
Asthma	__	__	__	__	________________________
Bleeding Disorder	__	__	__	__	________________________
Bronchitis (CHRONIC)	__	__	__	__	________________________
-Breast Cancer	__	__	__	__	________________________
-Colon Cancer	__	__	__	__	________________________
Cancer, Other ___________	__	__	__	__	________________________
Cataracts	__	__	__	__	________________________
Dementia (memory prob.)	__	__	__	__	________________________
Depression	__	__	__	__	________________________
Diabetes	__	__	__	__	________________________
Domestic Violence	__	__	__	__	________________________
Emphysema/COPD	__	__	__	__	________________________
Epilepsy	__	__	__	__	________________________
Fibromyalgia	__	__	__	__	________________________
Glaucoma	__	__	__	__	________________________
Gout	__	__	__	__	________________________
Heart Disease	__	__	__	__	________________________
Heartburn/Reflux/Hiatal	__	__	__	__	________________________

 HEALTH INFORMATION INVENTORY

Your name ___________________ Date of Birth ____________ Today's date_______

	You	Mom	Dad	Sis/Bro	Comment
Hepatitis	__	__	__	__	________________________
High Blood Pressure	__	__	__	__	________________________
High Cholesterol	__	__	__	__	________________________
Kidney problems	__	__	__	__	________________________
Liver Problems	__	__	__	__	________________________
Migraine Headaches	__	__	__	__	________________________
Mononucleosis	__	__	__	__	________________________
Multiple Sclerosis	__	__	__	__	________________________
Obesity	__	__	__	__	________________________
Osteoporosis	__	__	__	__	________________________
Pacemaker	__	__	__	__	________________________
Pneumonia	__	__	__	__	________________________
Prostate Problem	__	__	__	__	________________________
Rheumatic Fever	__	__	__	__	________________________
Sexual function issues	__	__	__	__	________________________
Schizophrenia	__	__	__	__	________________________
Stroke	__	__	__	__	________________________
Suicide Attempt	__	__	__	__	________________________
Thyroid Problems	__	__	__	__	________________________
Tuberculosis	__	__	__	__	________________________
Ulcers	__	__	__	__	________________________
Other: __________________	__	__	__	__	________________________
Other: __________________	__	__	__	__	________________________
Other: __________________	__	__	__	__	________________________

SURGICAL HISTORY (<u>excluding</u> pregnancy; see below):

Reason/Year _______________________________

____

____

____

Reason/Year _______________________________

____

____

____

Anything else you think we need to know regarding your health history?

____

____

 HEALTH INFORMATION INVENTORY

Your name ___________________ Date of Birth ____________ Today's date_________

For Females: Total # of pregnancies ____ Number of Live births ____ Stillbirth, miscarriage or abortion____ _____
Date of Last Menstrual Period _____. Are you pregnant? ____.

ALL PATIENTS:

I certify that the above information is correct to the best of my knowledge. I will not hold Kenneth W. Ponder, M.D., P.A. responsible for any errors or omissions that I may have made in completion of this form.

Patient/ Responsible Party Signature and Date:

____

Physician Signature and Date:

____

Name : Date of Birth: Date:

"Review of Systems"

How can we help you today? (check those that apply)
___ follow-up of my medical problems
___new problem(s)

---

other ____

Please circle the symptoms you are having. **Current symptoms only, please:**
General: fevers, chills, sweats, loss of appetite, fatigue, malaise, weight loss

Eyes: blurring, double vision, irritation, discharge, vision loss, eye pain, light bothers

Ear, Nose, and Throat: ear pain, discharge, ringing , decreased hearing, blocked nose , runny nose, nosebleeds, sore throat, hoarseness, difficulty swallowing

Cardiovascular(heart): chest pains, fluttering in heart, passing out,
shortness of breath on exertion, shortness of breath when lying down,
short of breath when lying down at night, swelling in feet

Respiratory (breathing): cough, shortness of breath, excessive sputum, coughing up blood, wheezing

Gastrointestinal(Stomach and bowels): nausea, vomiting, diarrhea, constipation, change in bowel habits, stomach pain, very black stools, blood in stools, dark yellow skin

Genitourinary: discomfort on urinating, having to get up at night to urinate, blood in urine, problems with erections, discharge, feeling like I have to urinate but cant, loss of urine, genital sores, or decreased interest in sex

Muscles, bones, and joints: back pain , joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis

Skin: rash, itching, dryness, sores I'm worried about

Nerves: paralysis, weakness, numbness, seizures, passing out , shakes, dizziness

Mental: depression, anxiety, memory loss, mental disturbance, suicidal thoughts, hallucinations, paranoia

Hormonal: cold intolerance, heat intolerance, extremely thirsty, extremely hungry, very frequent urination, weight change

Blood: abnormal bruising, bleeding, enlarged lymph glands
Allergic: itching, hay fever, infections that won't go away
Patient Signature:______________________________________ Date:___________
Doctor Signature:______________________________________ Date:___________

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________________________, have received a copy of Kenneth W. Ponder, M.D., P.A.'s Notice of Privacy Practices dated September 23, 2013.

__________________________ __________________

Signature Date

(The policy is located in the waiting room to the right of the reception window, or on our web page, http://www.bluewatermedicine.com under the forms tab.)

Patient Name (print)_________________________Date of Birth________________

Policy Disclosure Form 2017 – Bluewater Medicine /Kenneth W. Ponder, M.D., P.A.

(updated Feb 25, 2017)In case of life threatening emergency call 911.

2. For urgent medical problems call our office during regular office hours. After regular office hours, follow the instructions to leave a message for a return call, or call Twin Cities Hospital at (850) 678-4131 or your other hospital. They can provide urgent or emergent medical care for you at their emergency department.
3. Dr. Ponder concentrates on outpatient care and does not provide inpatient (hospital) care. A team of hospitalists will provide this care for you at the local hospitals.
4. Please cancel appointments, preferably 24 hours in advance, if unable to make them. We have an answering machine for your convenience.
5. For prescription refill requests, please call your pharmacy, even if no refills remain on your prescription. The pharmacy will then contact us. Please allow 2 business days. (Eglin AFB patients: contact us directly)
6. Women should select a gynecologist to do their women's health exams and provide pap smears (screening for uterine, ovarian, and cervical cancer) and do breast exams and mammograms (breast cancer screening). Many insurance companies, including Medicare cover this benefit.
7. Payment for service is due at the time of your visit unless other arrangements have been made. Patients with insurance pay for the portion not covered by insurance, such as co-payments and deductibles, at the time of treatment. We accept cash, checks, American Express, Discover, Visa, or Mastercard.
8. We do not perform workman's compensation or automobile injury evaluations and treatment.
9. I and/or my representative agree not to bring a frivolous medical malpractice case or cause of action against Kenneth W. Ponder, M.D, or Kenneth W. Ponder, M.D., P.A. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use a(n) expert medical witness(es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine who would typically have the background and experience to give an opinion on such a case."
10. Patient Self Determination Act: (Please circle yes or no)

    I have a living will: Yes No

    I have appointed a durable power of attorney for medical decisions: Yes No

    I have designated a health care surrogate: Yes No

If "Yes" then please give us copies of any of the above documents if you haven't done so already. Thanks.

11. **Prescription Issue Fee. You will be charged $25 per batch of prescriptions not handled at a face to face appointment. Insurance doesn't cover this fee. THIS FEE IS WAIVED FOR OUR MEDICARE CHRONIC CARE MANAGEMENT PATIENTS. Please ask for your prescriptions at your appointment. In most cases we issue the maximum refills allowed by law.**
12. Per Florida Law enacted June 2011, patients who are on controlled substances must be evaluated face to face at least every 3 months.
13. If you have any questions about these policies, please ask. We encourage your suggestions.

I understand the above policies

Signature_______________________________Date_____________

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

1. PATIENT INFORMATION.

NAME: ___________________________________

ADDRESS: ___________________________________

________________________, ___ __________

SSN: ______________

DATE OF BIRTH: __________________

2.AUTHORIZATION FOR RELEASE. I hereby authorize

____

___________________________________,

_________________________, ___ __________,

to release, disclose, and deliver the medical information described below to:

AUTHORIZED RECIPIENT: Kenneth W. Ponder, M.D., P.A.

4566 E Hwy 20 Ste 103

Niceville, Florida 32578-8831 VOICE: 850.897.1223. FAX 8**88**.423.5018

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of ALL medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment; (2) Mental health treatment (including psychiatric records); and (3) HIV-AIDS-related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity.

4. VALIDITY. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this shall not constitute a breach of my rights to confidentiality.

Specific Records Needed

__ Discharge summaries

__ Labs

__ Progress Notes

__ Other

_X LAST TWO YEARS ONLY UNLESS THIS LINE CROSSED OUT

I authorize the release of information as indicated above.

Print Name_____________________________________

Signature:____ Date: _____________

PRESCRIPTION FEE FAQ

1. **How much is it?** $25 cash, check, or credit card paid at time of prescription
2. **Medicine Chronic Care Management patients are exempt from this fee !**
3. **Does it apply at face to face appointments?** No
4. **Does insurance cover this fee?** No
5. **Does it apply to fax, electronic and email requests?** Yes, if not at a face to face appointment
6. **Does it apply to insurance prior authorization requests?** Yes.
7. **How long are prescriptions good for?** You have up to 6 months after the prescription is written to submit it to the pharmacy. In most cases we give the maximum number of refills allowed by law.
8. **Why this fee now?** We are being swamped with fax, electronic, phone call requests for refills. In many cases the patient was just in the office a few weeks ago. In other cases the patient would be better served by a face to face visit.
9. **What if my prescriptions don't all expire at the same time?** It doesn't matter; you have up to 6 months after the prescription is written to submit it to the pharmacy.
10. **Doesn't a prescription refill take very little time?** Actually, they take a lot of time – there are over a 100 a week. Patients ask for medicines for which they are allergic or that they are not supposed to be taking. Therefore each request requires a medical record review by physician.
11. **I'd rather not pay the fee, can I come in for a quick visit for prescriptions?** Sure. Just call and ask for an express visit (5 minutes). Insurance covers this, however you may be subject to copays

Chronic Care Management

Dear Patient / Caregiver:

I would like to invite you to participate in our new program. Chronic Care Management involves care that occurs between appointments such as phone calls, faxes, e-mails, prescription refills, prior authorizations, and communications with other members of your care team.

- Medicare now allows us to offer you this new program.
- Care has previously been fragmented where many different clinicians are treating the patient, but rarely do any of them communicate with each other. This program helps solve this problem.
- This enhanced care program proactively treats the patient between their regularly scheduled office visits.
- Medicare studies have shown that enrolling in the chronic care management program lessens the chance of hospitalization and reduces the chance of readmission. This, in turn, saves you money while benefiting your overall health and quality of life.
- Medicare is picking up the cost for this program. Standard copay and deductibles apply. Most, but not all, supplemental / secondary insurances pick up the copay. This cost share would most commonly be $8 per month if not covered by a secondary. This copay would only apply on months when more than 20 minutes of services were rendered.
- If less than 20 minutes of services are needed during a given month, then medicare is not billed.
- For the first month and first month only, there is a medicare covered initiation fee. The copay for this would be $13 if your secondary insurance doesn't cover chronic care management.
- Cancel at any time; there is no long-term contract.

Please return the consent form today. You can give it to us in person, **call us to give us verbal consent (ok to leave voice mail consent 24 hours a day) at (850) 897-1223 x201**, email it to bluewatermedicine@gmail.com, fax to 1-888-423-5018, or mail it to Kenneth W Ponder MD PA, 4566 E Hwy 20 Ste 103, Niceville, FL 32578.
The program is required for new patients, however most existing patients should sign up , as without it face to face appointments will be needed for all services chronic care management would otherwise cover.
If you have any questions please contact us at the contact numbers above.
Sincerely, Kenneth W Ponder MD

: V20170629

Dr. Kenneth W. Ponder
Internal Medicine

Agreement to Receive Chronic Care Management Services

Medicare, effective January, 2015 covers Chronic Care Management (CCM) services.

Dr. Kenneth W. Ponder is now able to provide Chronic Care Management (CCM) services, and I have been informed that I would benefit from CCM services, included those provided in between visits. In addition, I have been informed I meet the clinical eligibility to receive CCM services based on my diagnostic conditions.

The CCM services that Dr. Kenneth W. Ponder will provide me under this agreement include the following:

- Access to my care team 24 hours a day, 7 days a week, for urgent needs, including telephone access and other non-face-to-face means of communication (e.g., E-Mail),
- The ability to get successive, routine appointments with my designated primary care provider or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including:
  - » Referrals to other health care providers
  - » Follow-up after I visit an emergency department
  - » Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility)
  - » Coordination with home- and community-based providers of clinical services

My signature below indicates my understanding and agreement to receive CCM services and that I understand;

- Dr. Kenneth W. Ponder is designated by me for purposes of providing CCM to me and for submitting claims for payment to Medicare for the CCM services
- I will receive a copy of my comprehensive plan of care
- Dr. Kenneth W. Ponder is authorized to electronically communicate my medical information with other treating providers as part of the care coordination involved in CCM services
- Medicare will only pay one professional/ practice for CCM services provided to me during a calendar month,
- CCM services are subject to the usual Medicare deductible and coinsurance applied to my Medicare Part B services, and
- I can revoke this agreement at any time (effective at the end of the current calendar month) and can choose to receive these services from another physician or not to receive CCM services at all after the calendar month in which I revoke this agreement.

This agreement is effective as of the date below.

Professional/practice: ______________________________

Patient name (please print): ______________________________

Patient or guardian signature: ______________________ Date: __________

RE: Chronic Care Management / Tricare for Life / Federal BCBS member:

Dear Patient:

Although Medicare and <u>most</u> Medigap secondary policies cover chronic care management, it has come to our attention that Medicare secondaries Tricare for Life and Federal BCBS (FEP) do not.

Deductibles and cost shares will apply for Chronic Care Management Services. For most this will be $13 at signup and $8 a month, ONLY IN MONTHS WHERE MORE THAN 20 MINUTES OF NON FACE TO FACE CARE OCCUR (we keep computer assisted log of time, which includes interactions with members of your care team which may include consultants, pharmacists, therapists, family, you, etc.). If the part B Medicare deductible has not been met, these copays will be higher until the deductible is met.

Chronic Care Management signup is required for new medicare patients. Keep in mind though, if you disenroll, phone services will be mostly limited to making appointments. Services that used to be provided for free over the phone such as forms, prescriptions, including electronic prescriptions, relaying of lab results will need to be received in person at an appointment if you disenroll from Chronic Care Management. Time has changed, and in today's tough medical practice environment, we simply can no longer afford to provide this care unless covered by Chronic Care Management.

If you have any questions or suggestions, please let us know.

Sincerely,

Kenneth W Ponder MD

: V20170629