

Remote Patient Monitoring (RPM) Consent Form

I understand that:

- I am the only person who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring. I understand that I can only participate in this program with one Medical Provider at a time.
- I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.
- I understand the devices are only designed for the RPM program.
- I acknowledge that I received Blood Pressure Monitor Serial # : _____
- The device is meant to collect Blood Pressure Readings and transfer those readings to an online website. It is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7**. Call 911 for immediate medical emergencies.
- I am aware my BP daily readings will be transmitted from the monitor to a website located at www.myhealthconnected.net in a safe and secure manner. I can withdraw my consent to participate in this program, and revoke service at any time by returning the BP Monitor/Cuff device. _____ (name of healthcare professional) will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.
- I will do my best to take my BP every day. I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 30 days, and that this program is **NOT** a 24/7 Monitoring Service. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, _____ have read and understood the information (Print your name) and consent to participate in the Remote Patient Monitoring program as stated above. I am aware that this consent is valid as long as I'm in possession of the RPM equipment/device.

Date: _____ (dd/mm/yyyy)

Signature of Patient or Authorized Person (Relationship of Authorized Person)
