Remote Patient Monitoring Consent Form

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MN:

Remote Patient Monitoring (RPM) Consent Form

Member Information

Name:_____ Date of Birth:_____

Address:_____ Phone:_____

City:_____State:_____Zip:_____ Email:_____

Primary Care Physician:_____ Height:_____

Primary Care Physician #: _____

Medical Devices Received

I understand these devices are provided to me:

☐Blood Pressure Monitor ☐Pulse Oximeter ☐Glucose Device ☐Weight Scale

☐Tablet Serial No. _____ (Internal Use) **Language: English, Korean, or Spanish**

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 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 the misuse of the equipment.

• I understand the devices are only designed for the RPM program.

• The device is meant to collect Blood Pressure/Pulse Oximeter/Glucose, /Weight 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/Pulse Oximeter/Glucose/Weight daily readings will be transmitted from the monitor to a website located at www.eklotho.com safely and securely. I can withdraw my consent to participate in this program and revoke service at any time by returning the devices. The primary care physician listed above will securely and confidentially store my collected data and record and store my readings in my Electronic Medical Record monthly.

• I will do my best to take my BP/Pulse Oximeter/Glucose/Weight every day. I am aware that a Remote Patient Monitoring Qualified Health Professional will view my readings every 30 days, and that this program is NOT a 24/7 Monitoring Service. I will comply with the RPM services expectations and if I don't, I may be removed from the RPM services and will return the medical devices.

I, _____ (print name) have read and understood the information and give 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.

Patient Consent

Patient's signature:_____ **Date:**_____

Agent: PAT001

RPM Member Identification

A copy of Valid ID, Medicare Card, and Insurance ID must be submitted.

Place Valid ID Here

Place Medicare Card Here

Place Insurance Card Here

1. Complete and Sign Form
2. Place Cards Above
3. Take Horizontal Photograph of Page
4. Email Image to: RPM@proathletesteam.com

Agent: PAT001