Consent for Remote Patient Monitoring (RPM)

Successful Strategies HC

I, _____ understand that:

- I am the only person who should be using the remote monitoring equipment as instructed. I will not use 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, which is estimated at $150.

- I understand the devices are only designed for the Synsormed RPM program administered through Successful Strategies HC & MD Name and Title

  Blood Pressure Monitor Serial #:_____

  Glucometer Serial #: _____

  Pulse Oximeter Serial #: _____

  Scale Serial #: _____

- Your device is meant to collect medical data readings and transfer those readings to your chart. I am aware my daily readings will be transmitted from the monitor to your provider and the patient application on your smart phone or tablet. It is NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. Call 911 for immediate medical emergencies.

- Successful Strategies HC will securely and confidentially store collected data, record and store readings into my Electronic Medical Record on an ongoing basis as the readings are collected.

- I understand I can withdraw my consent to participate in this program, and revoke service at any time by returning the assigned device within 14 days either by mail with provided return shipping label or requesting pick up of the device. Should I fail to return the device I understand I will be charged $150 due immediately upon receipt of invoice.

- I promise I will do my best to take my readings every day. I am aware that (Insert MD Name and Title), will only view my readings every 30 days unless my case manager, whom I will be scheduled to speak with weekly and as needed, notifies the provider of abnormal results that require attention prior to the monthly review. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

However, I understand I can contact my provider during office hours at (702)xxx-xxxx, as well as the 24hr line at (702)xxx-xxxx

I, _____ have read and understood the information above and consent to participate in the Remote Patient Monitoring program administered by Successful Strategies HC. I am aware that this consent is valid as long as I'm in possession of the RPM equipment/device.

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Relationship of Authorized Person Witnessing Office Personnel Signature and Title