Remote Patient Monitoring Consent Form

PRO ATHLETES TEAM
HELPING OTHERS SUCCEED

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Consent Form | Remote Patient Monitoring (RPM)

Client Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Care Physician: _____ Primary Care Physician #: _____

Health History

Blood Pressure: ☐ Hypertension ☐ Coronary Artery

Other: _____

Pulse Oximeter: ☐ COPD ☐ CVD

Other: _____

Weight Scale: ☐ Obesity ☐ IBS

Other: _____

Glucose Meter: ☐ Diabetes ☐ Hyperlipidemia

Other: _____

Family History

Do you or did anyone in your family have any long-term health problems, like heart disease, diabetes, cancer, stroke, high cholesterol, COPD, or asthma?

☐ No If yes, please explain: _____

Medical Devices Received

I understand these devices are provided to me:

☐ Mobile Tablet ☐ Pulse Oximeter ☐ Weight Scale ☐ Glucose Meter ☐ Blood Pressure Monitor

Language: English | Korean | Spanish | Vietnamese

I understand that:

- I am the only person who should be using the health equipment as instructed. I will not use the device for reasons other than my health monitoring.
- 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 Remote Patient Monitoring program.
- The device is meant to collect Blood Pressure | Pulse Oximeter | Glucose | Weight Readings and transfer those readings to a secured, encrypted, HIPAA compliant server.
- If wish to discontinue, I am fully responsible to return all devices in workable condition to eKlotho.
- The primary care physician listed above, will securely and confidentially store my collected data and record and store my readings in my EHR (Electronic Health Record), monthly.
- I will do my best to use the equipment 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 am in possession of the RPM equipment/device.

Patient's Signature: _____ Date: _____

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

Referral Agent: _____

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: admin@rpmbypat.com

Agent: PAT001