PATIENT CONSENT FORM
REMOTE PATIENT MONITORING (RPM) PROGRAM

Patient Details

NAME _____

ADDRESS _____

_____

DOB _____ TEL (__ __ __) - __ __ __ - __ __ __

EMAIL _____

MRN_____

Medical Devices Supplied to Patient

The following Medical Devices have been provided to me:

● CareSimple 4G Blood Pressure Monitor ○ CareSimple 4G Glucometer ○ CareSimple 4G Weight Scale

By signing this Patient Consent Form, I hereby consent to **TEXAS KIDNEY INSTITUTE** providing Remote Patient Monitoring (RPM) services to me and agree to the following: **(Please initial every box)**

- ☐ The Medical Device(s) provided to me are the property of the Provider. I will not tamper with the Medical Devices and I understand that I am responsible for any costs and expenses related to the misuse of the Medical Devices. The Device cost is $200.00 and has been loaned to me by the provider.
- ☐ I will be the only one to use the Medical Devices as instructed by the Provider and I will not use the device for reasons other than health monitoring.
- ☐ The Medical Devices are to be used solely in connection with the RPM Services and associated RPM program provided by the Provider and not for any other purpose or use.
- ☐ The CareSimple Remote Patient Monitoring (RPM) system used by the provider, including the CareSimple Patient application that you will download on your personal smartphone and the associated Medical Devices are not a replacement for usual healthcare; they are a complement to assist us remotely in providing you long term care and health coaching.
- ☐ **THE RPM PROGRAM IS NOT A REPLACEMENT FOR EMERGENCY SERVICE. CALL 9-1-1 FOR IMMEDIATE MEDICAL EMERGENCIES AND DO NOT USE THE MEDICAL DEVICES IN REPLACEMENT OF THE 9-1-1 SERVICE.**
- ☐ The length of time I am on the RPM program will be determined by the Provider at its sole discretion and I may be removed from the RPM program at any time.
- ☐ My data and medical information obtained from my participation in the RPM program may/may not be considered part of my patient record, but may be shared with other health care professionals to enhance my care and I authorize such professional disclosure. My data and information will be securely transmitted data and reviewed at the clinician's discretion.
- ☐ I will comply with the RPM program clinical expectations and if I don't, I may be removed from the RPM program and I will return the Medical Device(s).
- ☐ I have the right to withdraw my consent to participate in the RPM program and stop receiving RPM Services at any time. I understand in order to not accrue additional charges after my decision, I will notify the office and return the device to Texas Kidney Institute.
- ☐ If I am unable to take my blood pressure every day, I will send a minimum of 18 days of readings within a calendar month. If I do not meet the required minimum of days, my account may be billed $60.00 for that month.

Patient Consent

Patient Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

In the event that the patient is unable to give consent due to mental or other capacity issues, the relative, or carer who has Lasting/Durable Power of Attorney for health and welfare responsibility, may give consent if deemed to be in the best interest of the patient. In these instances, the carer/relative should sign below.

Carer/relative print name: _____ **Signature:** _____ **Date:** _____