Remote Patient Monitoring Consent Form

PATIENT NAME _____ MD NAME _____
EMERGENCY CONTACT _____ INSURANCE TYPE _____

By signing this agreement, I understand and agree to the following terms:

- I have received education on RPM services and my telemonitoring service plan by my healthcare provider.
- I am the only person who can use the RPM device. I will only use this device for my own personal health monitoring, as instructed by my healthcare provider. The devices are only designed for the iUGO Care RPM program.
- The RPM equipment needed to monitor my health remains the property of _____ and will be returned when RPM services end. I will not tamper with the equipment. I am responsible for payments for loss or damage of equipment.
- The RPM device is meant to collect health data only and transfer them to an online platform. **The RPM program is not an emergency response unit and is not monitored 24/7**. Call 911 in the case of a medical emergency.
- My personal health information will be transferred remotely, privately and securely from the device to be stored confidentially in the iUGO Care platform. My healthcare provider and their clinical staff will have access to my health information.
- I authorize electronic communication of my health information with other treating providers as part of coordination of my care.
- I authorize the release of my medical information by my healthcare provider to authorized representatives of Medicaid, Medicare, or other insurance carriers for determining benefits.
- I authorize my healthcare provider to disclose necessary health information to other vendors whose services may be required in conjunction with the RPM program.
- As applicable Medicare, Medicaid or other health insurance benefits for RPM will be applied. There may be a copay with RPM services, and I may be billed for a portion.
- If I lose capacity to consent, an authorized person must receive informed consent on my behalf to continue receiving RPM services.
- I have the right to withdraw from RPM services at any time.

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

Date (dd/mm/yyyy): _____

_____ _____
Signature of Patient or Authorized Person Relationship of Authorized Person