HEART& VASCULAR CLINIC

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Remote Patient Monitoring Enrollment Form

Patient Name: Date of Birth:

Thank you for joining the Heart & Vascular Remote Patient Monitoring Program (RPM). Through this program, we will monitor your blood pressure remotely using the provided blood pressure monitoring device and gateway. Our objective is to deliver personalized and timely care to optimize your blood pressure and overall cardiovascular health.

By agreeing to participate, you are consenting to the following terms:

- Blood pressure readings will be conducted daily, and you are required to complete at least 16 days of readings within a 30-day period. Failure to do so may result in unenrollment from the program, requiring the return of the device.
- Your insurance will be charged monthly for the Remote Patient Monitoring Program. Regardless of monthly office visits, you are responsible for payment, including any applicable copays depending on your insurance. We will monitor your monthly blood pressure readings and care management time.
- Your health information may be shared electronically with your healthcare team for optical care coordination. All data collected will be treated with utmost confidentiality, accessible only to authorized healthcare providers involved in your care.
- Prompt communication of any health concerns is expected.
- Disclosure of enrollment in similar remote blood pressure monitoring programs anywhere else is mandatory.
- In care of device damage, loss, or malfunction, you may be billed $125.00 for device replacement.

I understand that my participation is voluntary, and I reserve the right to withdraw without affecting my regular medical care. The service can be discontinued by either party at any time, with the termination effective at the end of the calendar month.

I, _____, acknowledge, understand and agree to the contents of this form.

Patient Signature _____ Date_____