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| A picture containing flower  Description automatically generated | **Remote Patient Monitoring (RPM) and/or**  **Chronic Care Management (CCM) Consent Form** |
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| You are eligible to participate in Guardiant Health’s Remote Patient Monitoring (RPM) and/or Chronic Care Management (CCM) program. This lets us remotely monitor your vital signs and intervene as needed to keep you safe and healthy at home.  Please read through each of the statements below. By checking each box, you consent to participate in the Guardiant Health RPM program. | |

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| **I understand that:** | |
|  | Guardiant Health complies with all laws related to the privacy and security of my health information. Guardiant Health and the device manufacturer may access my information and data for the purposes of health monitoring, providing technical support, troubleshooting and overall performance improvement. |
|  | I have been provided with a tablet along with wireless devices that may include: weight, blood pressure and pulse oximetry measuring devices. My kit comes with a user guide to help me understand how to use the equipment. I am responsible for using all devices as instructed for my vital signs and to take precautions to avoid damage while using the equipment. I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment. |
|  | I am the only person who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring. |
|  | I understand the devices are only designed for the RPM and/or CCM program. |
|  | I will do my best to take my vitals every day. I understand that my data will be reviewed at a minimum once daily during office hours; re-tests that are transmitted may not be viewed until the next day. I will be contacted to review any levels that fall out of range. |
|  | This is a monitoring device. **It is not an emergency response device.** I willl call 911 for immediate medical emergencies. |
|  | I am aware my vital readings will be securely transmitted from the tablet via bluetooth to my Guardiant Health RPM/CCM provider. I authorize Guardiant Health to electronically share my health information with others involved in my care. Guardiant Health will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record. |
|  | I agree to designate a Guardiant Health clinical team member as my RPM/CCM provider. Other Guardiant Health staff team members will talk to me about my remote monitoring, but I understand that all care provided by Guardiant Health is supervised by my RPM/CCM provider. |
|  | By participating, I acknowledge that electronic systems, including telephone, video and other equipment can fail at times. I agree to not hold Guardiant Health or its vendor liable for any consequences that may arise from the delivery of RPM and/or CCM services or from system failure. |
|  | I can withdraw my consent to participate in this program and revoke services at any time for any reason and this will not have any effect on my usual primary care services. My signature is required to end RPM and/or CCM services and I must submit a RPM and/or CCM Revocation Form. Withdrawing my consent will require returning all wireless medical devices that are part of the RPM and/or CCM program. |
|  | I am aware that this consent is valid as long as I’m in possession of the RPM and/or CCM equipment/device(s). |
| **Please check one of the following:** | |
|  | Medicare beneficiary  I have read and understand the information and consent to participate in the RPM and/or CCM program as stated above. I authorize Guardiant Health to bill Medicare for the RPM and/or CCM program services I receive. The RPM and/or CCM services are a covered Medicare benefit and normal copays apply. |
|  | Subscription patient  I have read and understand the information and consent to participate in the RPM and/or CCM program as stated above. I understand Guardiant Health will charge me a monthly subscription fee as stated in my *Remote Patient Monitoring Service Agreement.* |

(Printed patient full legal name)

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|  |  | Date: |
| (Signature of patient or legal guardian/power of attorney) | | (dd/mm/yyyy) |

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|  |  | Date: |
| (Printed name of patient or  legal guardian/power  of attorney) | (Legal guardian/power  of attorney relationship  to patient) | (dd/mm/yyyy) |