PENINSULA NEPHROLOGY ASSOCIATES, P.A.

1821 Sweetbay Dr Ste 1
Salisbury, MD 21804
PHONE 410-546-4427
FAX 410-546-2096

11107 Racetrack Rd
Berlin, MD 21811
PHONE 410-973-2731
FAX 410-973-2993

165 Market St Ste 6
Onancock, VA 23417
PHONE 410-546-4427
FAX 410-546-2096

Remote Patient Monitoring (RPM) Consent Form

Do you have a pacemaker? Yes or No

Insurance Coverage: _____

Provider Seen: _____

- This is an insurance covered program. We provide you with a monitor that you will use to check your blood pressure. I understand that I can only participate with one Medical Provider at a time.
- I will not tamper with the equipment or packaging. I understand that I am responsible for any fees associated with misuse of the equipment.
- I understand the devices are only designed for the RPM program, and not personal use.
- I acknowledge that I received Blood Pressure Monitor Serial #: _____
- I am aware my BP daily readings will be transmitted from the monitor to the software located at 2chealthsolutions.com in a safe and secure manner. I can withdraw my consent to participate in this program, and revoke service at any time by returning the BP Monitor/Cuff device.
- It is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. I understand that I must Call 911 for immediate medical emergencies.**
- **I am required to take my BP every day.** I am aware that a Remote Patient Monitoring Qualified Health Professional will review my readings for any inconsistencies, I will be contacted every day if I fail to take my blood pressure daily, also I can chat with the RPM Coordinated thru the chat messages within the app itself.

******Please note that if I do not comply with the program's requirements it is my responsibility to return the *Monitor and box* to the office within a timely manner, or I will be charged a fee of $80.00**

******I hereby authorize Peninsula Nephrology Associates providers and staff to communicate with me via unencrypted text messages if I have provided a mobile phone number.**

I, Patient Name (Print): _____ Patient's DOB: _____ 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 as long as I'm in possession of the RPM equipment/device.

Signature of Patient or Authorized Person (Relationship of Authorized Person):
X_____

Print Name of Patient or Authorized Person:

_____

Contact phone Number: _____ **(Home or Mobile)**

Date: _____