



Remote Patient Monitoring (RPM) Program

Authorization Agreement

By signing this form, I have agree and understand the following:

- 1) I am the only person permitted to use the remote patient monitoring (RPM) equipment.
- 2) I will use the RPM equipment as instructed; I will not use the RPM equipment for any reason other than to monitor my own personal health.
- 3) I will not alter or tamper with the RPM equipment. I may be responsible for the replacement cost if I damage the equipment.
- 4) My data will be electronically transmitted from the RPM equipment to InstaClinic's Carium platform in a safe and secure manner.
- 5) I will do my best to take my measurements every day, or at least 3 times per week.
- 6) A qualified health professional will view my remote patient monitoring readings every thirty (30) days. I will be contacted every thirty (30) days by phone or secure message to review and discuss my results and progress. If there are any abnormalities or my treatment must be changed, I may be contacted more frequently.
- 7) The RPM equipment is not designed as an emergency response unit and is not monitored 24/7. I will call 911 for any medical emergencies.
- 8) The only possible associated costs to me for using the remote monitoring devices may be standard co-pays or deductibles that my insurance may not cover.
- 9) I may withdraw my consent to participate in the remote patient monitoring program and stop participating at any time by notifying my provider. Upon my withdrawal from the program, I will return the RPM equipment to my provider within fourteen (14) days.

I hereby authorize InstaClinic to provide remote monitoring services to me. My provider will direct the details and frequency of the remote monitoring services that have been discussed with me. I further state that I have read and understand the above authorization; and any questions that I had regarding the devices or use of the devices for my medical care have been answered to my satisfaction. I have had all the details of remote monitoring explained to me, and I am fully familiar with the contents of this authorization. I understand the devices I am to receive will be in good working condition, and I agree to return them in the same condition. I hereby agree to participate in the remote monitoring program as explained, under the terms described herein.

I, _____ *(patient signature)*, have read and understood the information above. I hereby consent to participate in the Remote Patient Monitoring program.

Date: _____