ANDERSON MEDICAL GROUP
OF TEXAS
YOUR HEALTH. OUR CARE.

Howard E. Anderson II, M.D.
Diplomate, American Board of Internal Medicine

Remote Patient Monitoring Consent Form

Medical Devices Supplied to Patient

The following Medical Devices have been provided to me:

- ☐ Humhealth Gateway — Serial #: _____
- ☐ Humhealth Blood Pressure Monitor — Serial #: _____
- ☐ CM Fingertip Oximeter — Serial #: _____
- ☐ VivaGuard Blood Glucose Meter — Serial #: _____
  - Lancing Device Lot #: _____
  - Lancets Lot #: _____
  - Test Strips Lot#: _____

I understand that:

- I am the only person who will be using the remote monitoring equipment as instructed. I will only use the device for my own personal health monitoring. I understand that I can only participate in this program with one Medical Provider at a time. I understand the devices are only designed for the AMG of Texas RPM program.
- I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.
- The device is meant to collect Blood Pressure, Weight, and/or Glucose Readings and transfer those readings to an online website. It is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7**. Call 911 for immediate medical emergencies.
- I am aware my daily readings will be transmitted from the monitor to a website hosted by HumHealth 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 above listed devices. The Anderson Medical Group of Texas will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.
- **BP/Weight/Glucose readings must be taken a minimum of 16 times per month.**
- I am aware that a Remote Patient Monitoring Qualified Health Professional will view my readings at least once every 30 days, and that this program is **NOT a 24/7 Monitoring Service**. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, _____ have read and understand the information and consent to participate in the Remote Patient
(Printed Name)

Monitoring program as stated above. I am aware that this consent is valid while I'm in possession of the Anderson Medical Group of Texas RPM equipment.

_____ Date (MM/DD/YYYY)

_____ Printed Name of Patient or Authorized Person

_____ Signature of Patient or Authorized Person

_____ Relationship of Authorized Person