SSMHealth

Agreement for Remote Patient Monitoring

I, _____ give permission to SSM Health to provide remote patient monitoring services to me.

I understand that:

1. The goals of the SSM Health Remote Patient Monitoring Program ("Program") are as follows:
   a. To reduce patient risk of needing emergent care and/or re-hospitalization by monitoring patient health data trends.
   b. To provide education about patient diagnoses, lifestyle modifications, and daily health self-monitoring strategies.
   c. To assist the patient and/or caregiver(s) with applying the education and self-monitoring strategies with the ultimate goal of discharge from the Program and transition to self-monitoring.
2. The Health Recovery Solutions (HRS) Remote Patient Monitoring System ("Device") is not an emergency response device. In case of immediate medical emergency, I understand I must call 911 for local Emergency Service.
3. Initial assigned daily readings must be completed by 12:00pm CST in order to allow time for follow up when warranted. If a patient and/or caregiver is unable to keep this schedule, they must contact SSM Health.
4. My data is transmitted to SSM Health and is reviewed daily between 8:00 a.m. and 4:00 p.m. CST only. If I take my vitals late in the day (i.e. after 4:00 p.m. CST) this information will not be reviewed until the next day.
5. I (or my caregiver) must be reasonably available for follow up communication and/or re-testing of readings if requested.
6. Some patient interactions may be conducted virtually via the secure video visit feature of the Device or via telephone.
7. Information obtained from the Device is considered part of my medical record and may be shared with other health care providers as permitted by law and/or authorized by me.
8. SSM Health may share deidentified information with others, both inside and outside SSM Health, to assess care provided to me and the benefits of remote patient monitoring. However, none of this information will identify me.
9. I may be discharged from the Program at any time if any of the following conditions are met:
   a. I have achieved all of the Program goals.
   b. I request discharge.
   c. My health care provider orders discharge from the Program.
   d. I am unable to adhere to Program expectations.
10. The Device, including all related equipment, is the property of HRS and is leased by SSM Health. I understand that a maintenance and inspection process of the Device was completed before it was sent to me and that the Device is in proper working order. I understand I am responsible for replacement costs of up to $2000 if there is any damage, disassembly of the Device or if SSM Health or HRS are unable to retrieve the Device. I understand that I am required to return the Device upon discharge from the Program.

I acknowledge that:

1. If I feel ill, or the results from the Device suggest that I call my health care provider, I will contact my primary care provider or call 911 for assistance. I understand that SSM Health, its agents, employees, and successors and assigns will not be held liable for any complications, injury, or death that occurs as the result of my negligent use of the Device or my use beyond the Device's educational intentions.
2. I am the only person who will use the Device and that I have the right to refuse the Device at any time.
3. I have received the Device and the Program welcome letter.
4. I am responsible for any costs or copayments associated with the Program that are not covered by my insurance.

I assign payment of health care benefits, otherwise payable to me, directly to SSM Health, not to exceed its regular charges. I understand that I am financially responsible to SSM Health for charges not covered by this authorization.

_____ _____

Patient/Legal Representative Signature Date