FAX

SEQUOIA
Integrative Medical Services

SEQUOIA FAX NUMBERS:

Central Fax: (920) 543-5288
Western Fax: (715) 520-5288

To: Sequoia Admissions **Date:**

From: **Phone:**

Fax: **Pages:**

Subject:

Comments:

NEW PATIENT ADMISSION CHECKLIST

********** ATTENTION FACILITY HEALTH CARE PARTNERS **********

<u>PLEASE NOTE</u>: All of the below required documentation must be received and fully completed PRIOR to the initial face-to-face by a Sequoia Practitioner. New patients WILL NOT be scheduled until all documentation has been recieved and reviewed.

- ☐ Patient Health Insurance: Please include an up-to-date copy of all insurance cards:
  - ☐ Medicare #
  - ☐ Medicaid #
  - ☐ Supplemental Insurance #
  - ☐ Veteran Status, Military Branch and VA insurance card
- ☐ Advance Directive / Living Will / DNR Documentation
- ☐ Facesheet
- ☐ Current Medication List
- ☐ Most recent history and physical and/or discharge summary from last PCP visit or hospital visit
- ☐ List of most recent doctors / specialized care providers
- ☐ Sequoia Admission Packet – FULLY COMPLETED
  - ☐ Notice of Privacy Practices (NPP)
  - ☐ Patient Admission Information sheet
  - ☐ Release of Information form
  - ☐ Consent for Medical Care and Treatment form
  - ☐ New Patient Questionnaire form
  - ☐ Chronic Care Management (CCM) form
  - ☐ Telehealth & Urgent Care Services form
  - ☐ Remote Patient Monitoring (RPM) form

Revised 04/06/2026

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review this notice carefully.

Esta información está disponible en español. (This information is available in Spanish.)

This notice applies to all protected health information* ("PHI") maintained by Sequoia Integrative Medical Services, LLC, and Sequoia Health Services ALF, LLC (collectively, "Sequoia"). This notice will be followed by all members of Sequoia's Workforce, including employees, medical staff members, students and volunteers, with respect to PHI maintained by Sequoia. If you have any questions after reading this Notice, please contact Sequoia's HIPAA Privacy Officer or designee.

* Protected Health Information (or PHI) is any individually identifiable health information, whether oral, written, or electronic, transmitted or maintained in any form or medium that is created or received by a health care provider, a health plan, or a health care clearinghouse; and relates to an individual's past, present, or future physical or mental health condition or health care treatment, or the past, present or future payment for health care services to the individual; and either identifies an individual (for example, name, social security number or medical record number) or can reasonably be used to find out the person's identity (address, telephone number, birth date, e-mail address, and names of relatives or employers).

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We are committed to the protection of PHI in accordance with applicable law and accreditation standards regarding patient privacy. The health information about you is personal. This information may consist of paper, digital or electronic records but could also include photographs, videos and other electronic transmissions or recordings that are created during your care and treatment. We may use a secure AI tool to audio record your visit and assist with documentation of your visit. Your provider reviews and approves all notes. You are free to decline the use of AI in documenting your visits. If you do not want us to use this technology, please advise your provider. Audio recordings are temporarily saved in a secure manner until note summaries and quality checks are complete, and then they are automatically deleted. A record of the care and services you receive is needed to provide you with quality care and to comply with legal requirements.

The law requires us to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Notify you in the event of a breach of your Unsecured PHI.
- Follow the terms of this Notice that are currently in effect.

When releasing your PHI, Sequoia will follow a "Minimum Necessary" standard, whereby we will make reasonable efforts to limit the use & disclosure of your PHI in order to accomplish the intended purpose or job.

Uses and disclosures of health information not covered by this Notice or the laws that apply to Sequoia will be made only with your authorization.

In certain circumstances Sequoia may use and disclose PHI about you without your written consent as follows:

- **Treatment**: We will use health information about you to provide you with medical treatment or services. We will disclose PHI about you to doctors, nurses, technicians, students in health care training programs, or other

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personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes might slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals.

- **Payment**: We will use and disclose your PHI to send bills and collect payment from you, your insurance company, or other payers, such as Medicare, for the care, treatment, and other related services you receive. We may provide your name, address and insurance information to other health care providers related to your care. We may tell your health insurer about a treatment your doctor has recommended to obtain prior approval to determine whether your plan will cover the cost of the treatment. For billing information, contact Clarity Health RCM at sequoiabilling@clarityhealthrcm.com, (708) 529-6521 or (920) 204-6754.
- **Health Care Operations:** We may use and disclose PHI about you for the purpose of our business operations. These business uses and disclosures are necessary to make sure that our patients receive quality care and cost-effective services. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of our staff, contracted employees and students in caring for you. We may use or disclose your PHI to an outside company that assists us in operating our facilities. For example, when your provider dictates a summary of the visit with you, an outside company types up the document for our medical records. These outside companies are called "business associates," who have contracted with us to keep any PHI received from us confidential in the same way we do.
- **Family Members and Friends:** We may disclose PHI about you to a family member, relative, or another person identified by you who is involved in your health care or payment for your health care. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest under the circumstances.
- **Future Communications:** We may use your name, address, e-mail and phone number to contact you to provide you information about new programs or other services we offer. An example of this would be mailers to all patients regarding a walk or run for breast cancer. This same information may be used to develop new programs as part of promoting health.
- **Public Health and Government Functions:** We will disclose your PHI in certain circumstances to:
    - Control or prevent a communicable disease, injury or disability, to report births and deaths, and for public health oversight activities or interventions.
    - The Food and Drug Administration (FDA), to report adverse events or product defects, to track products, to enable product recalls, or to conduct post-market surveillance as required by law.
    - A state or federal government agency to facilitate their functions.
- **Required or Permitted by Law:** We will disclose your PHI when required to do so by federal, state, or local law. We are permitted, and required in some cases, to release your PHI in certain circumstances to:
    - Report suspected elder or child abuse to law enforcement or other governmental agencies responsible to investigate or prosecute abuse.
    - Respond to a valid court order.
    - The Department of Health Services (DHS), the Department of Children and Families (DCF), a protection or advocacy agency, and law enforcement authorities investigating abuse, neglect, physical injury, death, and suspicious wounds, burns, or gunshot wounds.
    - Your court-appointed guardian or agent you have appointed under a health care power of attorney.

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  - A prisoner's health care provider.
  - A medical examiner, coroner, and funeral director regarding a death.
  - Law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons.
- **Workers' Compensation:** We will disclose your health information that is reasonably related to a worker's compensation illness or injury following written request by your employer, worker's compensation insurer, or the Department of Workforce Development or its representative.
- **Employer-Sponsored Health and Wellness Services:** We maintain PHI about employer-sponsored health and wellness services we provide our patients, including services provided at their employment site. We will use the PHI to provide you medical treatment or services and will disclose the information about you to others who provide you medical care. For employer-sponsored services provided at your employment site, summary, de–identified information may be provided to your employer for planning purposes. If you wish to have detailed health information provided to your employer, you must complete an authorization for release of PHI.

YOUR PROTECTED HEALTH INFORMATION RIGHTS

- **Right to Request Restrictions:** You have the right to request certain restrictions of our use or disclosure of PHI for treatment, payment, or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. We are not required to agree to your request in most cases. If we agree to the restriction, it will comply with your request unless the information is needed to provide you emergency treatment. We must, however, agree to your request to (1) restrict our disclosure of your PHI to your health plan when you have paid us out–of–pocket in full for the health care item or service we provided you and (2) restrict our disclosure of your immunization data to the Wisconsin Immunization Registry. A request for restriction should be made in writing. To request a restriction, please contact Sequoia.
- **Right to Access:** You have the right to access PHI about you that may be used to make decisions about your health. A request to inspect your records may be made to Sequoia. Your request must be in writing, and we may request that you use our form. There may be a charge for copies.
- **Right to Amend:** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information, for as long as we maintain the information. Requests for amending your PHI should be made in writing to Josie Lenz, Admissions Manager. Sequoia will respond to your request within 60 days after you submit the written amendment request form. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of instances in which we or our Business Associates disclosed your PHI for purposes other than treatment, payment, health care operations, disclosures authorized by you or made to you, and certain other activities. To request this accounting of disclosures, you must submit your request in writing to Josie Lenz, Admissions Manager. We will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.
- **Right to Request Alternate Means of Communication:** You have the right to request that we communicate with you about your PHI in a certain way or at a certain location. We will accommodate all reasonable requests. You must make any such request in writing submitted to Josie Lenz, Admissions Manager.

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- **Right to Require Authorization:** Your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI.
- **Right to Revoke Authorization:** If you authorize Sequoia to use or disclose your PHI, you may revoke that authorization, in writing, at any time. We are unable to take back any disclosures we have already made with your permission. To revoke an authorization you must contact Josie Lenz, Admissions Manager.
- **Right to Complain:** If you believe your privacy rights have been violated, you may file a complaint with Sequoia or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Sequoia, you must put your complaint in writing and address it to Katelyn Wery, LPN, Director of Clincial Services. This person will assist you in filing your complaint and the necessary paper work. Filing a complaint will not affect your care and treatment.
- **Right to Require Authorization:** Your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI.

Important Notice: We reserve the right to revise or change this Notice and to make the new Notice provisions effective for all PHI Sequoia maintains. The most current copy of this Notice will be available for you. You have a right to obtain a paper copy of this Notice upon request.

How to Contact Us:
Sequoia Integrative Medical Services
Attn: Josie Lenz, Admissions Manager
1746 Paul Drive
Kaukauna, WI 54130
Phone: (920) 372-4168
Fax: (920) 543-5288
Email: admissions@sequoiaintegrativemedicalservices.com

Office for Civil Rights, Region V
U.S. Department of Health and Human Services
233 North Michigan Ave., Suite 240
Chicago, IL 60601
Voice Phone: 800-368-1019
Fax: 202-619-3818
TTD: 800-537-7697
Email: ocrmail@hhs.gov

EFFECTIVE DATE: January 14, 2020

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PATIENT ADMISSION INFORMATION

PATIENT INFORMATION

Full Name: _____ **Date of birth:** _____

Nickname / Preferred Name: _____ **Gender:** ☐ M ☐ F ☐ Other

Code Status: ☐ Full code ☐ DNR ☐ DNI ☐ Other: _____

FACILITY INFORMATION

Facility Name: _____

Address: _____

Phone: _____ **Unit / Building / Room #:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Member ID: _____ **Group Number** (if applicable)**:** _____

Medicare Coverage: ☐ Part A ☐ Part B ☐ Both

Secondary Insurance (if applicable)**:** _____

Member ID: _____ **Group Number** (if applicable)**:** _____

BILLING ADDRESS

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

LEGAL REPRESENTATIVE / ACTIVATED POA / EMERGENCY

POA Name: _____ ** Please attach APOA documentation if applicable.*

Relationship to Patient: _____ **Phone:** _____

Email: _____

Mailing address: _____

Emergency Contact: _____ **Phone:** _____

PATIENT PORTAL ACCESS

Would the patient or legal representative like access to the patient portal? ☐ Yes ☐ No

Email address for portal access: _____

**A portal invitation will be sent to this email to create login credentials.*

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RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Full Name: _____ **Date of birth:** _____

Address: _____ **Phone:** _____

ORGANIZATION AUTHORIZED TO REQUEST RECORDS

Organization Name: Sequoia Integrative Medical Records

Contact Person: Josie Lenz, Admissions Manager **Phone:** (920) 372-4168

Email: admissions@sequoiaintegrativemedicalservices.com **Fax:** (920) 543-5228

HEALTHCARE PROVIDER HOLDING THE RECORDS

Provider / Facility Name: _____

Address: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE REQUESTED

☐ Complete Medical Record ☐ Lab Results ☐ Medication Records

☐ Office Visit Notes ☐ Imaging / Radiology Reports ☐ Billing Records

☐ Other: _____

Date range of records (if applicable): ___/___/___ to ___/___/___

PURPOSE OF REQUEST

☐ Continuing Medical Care ☐ Legal ☐ Personal Records ☐ Insurance / Claims

☐ Other: _____

AUTHORIZATION

Option 1 – Patient Authorization

☐ I am the patient and authorize the release of my medical records as described above.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Option 2 – Authorized Representative (Family / Legal Guardian)

☐ I am authorized to act on behalf of the patient and I give permission to request the patient's records.

Representative Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ POA ☐ Next of kin ☐ Other: _____

Representative Signature: _____ **Date:** _____

Revised 04/06/2026

CONSENT FOR MEDICAL CARE AND TREATMENT

CONSENT TO DIAGNOSE AND TREAT: I understand that Sequoia Integrative Medical Services, LLC and its affiliates including Sequoia Health Services ALF, LLC (collectively, "Sequoia") is a family medicine practice that provides medical evaluation and treatment services through primary care providers. I hereby voluntarily consent to treatment, services and procedures as ordered by Sequoia's physician or non-physician advanced practice provider. Such treatment, services, and procedures may include, but are not limited to: examinations, blood draws, laboratory analysis, monitoring, medications, and other therapies. The purpose of our medical and psychological evaluation is to assess overall health and care needs. We may use a secure AI tool to audio record your visit and assist with documentation of your visit. Your provider reviews and approves all notes. You are free to decline the use of AI in documenting your visits. If you do not want us to use this technology, please advise your provider. I understand that student nurses and others in professional training programs may be among the individuals, employee, and subcontractors who participate in my care.

TELEHEALTH CONSENT: Telehealth is a way to provide treatment and evaluation through the use of electronic communications. It allows me to receive services from any place, including my home, while the provider is at a different location. With telehealth services, I understand that there is a risk that my provider cannot examine me as closely as they would at an in person office visit and that the provider may decide that I still need an office visit. I understand that there may be technical problems that interrupt or stop a visit before we are done. Sequoia uses telehealth technology that is used to protect your privacy. To help ensure your privacy, you should use a network that is private and secure and access services where your communications can be private.

NOTICE OF PRIVACY PRACTICES: I have received the Sequoia's Notice of Privacy Practices and authorize its associates and/or designees to discuss and provide documentation of my medical history, diagnosis, treatment and prognosis as described therein. It is the policy of Sequoia not to release confidential medical information to a patient's family members without the patient's written consent, which must be provided on a separately signed form.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consent.

Patient Name	DOB
Signature of Patient	Date
Signature of Legal Representative / Relationship	Date

Revised 04/30/2026

NEW PATIENT ADMISSION QUESTIONNAIRE

Patient Name: _____ **Date of birth:** _____

Facility Name: _____ **Patient room #:** _____

Pharmacy: _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Does this patient have a WI DNR Form? ☐ Yes ☐ No

Does this patient have a WI DNR Bracelet? ☐ Yes ☐ No

Does this patient have a Cert. of Incapacity? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

Has a family member had any of the conditions below?

☐ Diabetes ☐ Cancer ☐ Heart disease ☐ High blood pressure ☐ Tuberculosis

Other: _____

HOSPITALIZATIONS

Has this patient been hospitalized in the last 12 months? ☐ Yes ☐ No

If yes, please list reason(s) and date(s): _____

_____

_____

PERSONAL HEALTH HISTORY

(Please include a list of diagnosis.)

☐ Heart Disease	☐ Respiratory Disease	☐ Difficulty Hearing
☐ Thyroid	☐ Mental Illness	☐ ENT – Sinus/Colds
☐ Seizures	☐ Back injury	☐ Hepatitis/Jaundice
☐ Stomach Ulcer	☐ High blood pressure	☐ Kidney Disease
☐ Stomach/Gallbladder	☐ Hernia	☐ Chronic Pain
☐ Seasonal allergies	☐ Arthritis/Gout/Joint Disease	☐ Nervous Disorder
☐ Vision/Eye Disorders	☐ Diabeties I / II	☐ Muscular Disease
☐ Headaches	☐ Cancer	☐ Fainting/Dizziness

Additional details: _____

_____

_____

_____

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ALLERGIES

Please list allergies and any known reactions.

_____ _____

_____ _____

_____ _____

MEDICATIONS & DOSAGE

Please attach current medication list.

SOCIAL HISTORY

Current smoker? ☐Yes ☐No **Former smoker?** ☐Yes ☐No If yes, how long? _____

How many packs per day? _____ Quit date? _____

Currently use drugs? ☐Yes ☐No **Used drugs in the past?** ☐Yes ☐No

If yes, how long has/did the patient use drugs? _____ Quit date? _____

Currently drink alcohol? ☐Yes ☐No **History of alcohol abuse?** ☐Yes ☐No

If yes, how long many drinks per week? _____

LABORATORY RESULTS

*Please include a copy of results if available.

Date of most recent laboratory results: _____

ADDITIONAL INFORMATION

Bladder / Bowel: ☐Continent ☐Incontinent ☐Other: _____

Vision: ☐Wears glasses ☐Does not wear glasses ☐Reading only

Hearing: ☐Hearing aids / Devices ☐Other: _____

Mobility: ☐None ☐Cane ☐4WW ☐2WW ☐Manual W/C ☐Broda W/C

Transferring Device (Hoyer, EZ Stand, etc.): _____

ADLs: ☐Independent ☐1 Assist with Cares ☐2 Assist with Cares

Diet: ☐Regular ☐Mechanical soft ☐Pureed ☐Diabetic ☐NAS/Cardiac

☐Other: _____

CURRENT THERAPY SERVICES

(Patient is receiving these services at this time.)

☐Physical therapy ☐Occupational therapy ☐Speech therapy ☐Skilled nursing

Service Provider/Company Name: _____

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CHRONIC CARE MANAGEMENT (CCM)
Enrollment Informed Consent

What is Chronic Care Management (CCM)?

Chronic Care Management (CCM) are services by a physician or non-physician practitioner (Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only practitioner can bill CCM per service period (month).

- Use of a Certified Electric Health Record (EHR)
- Continuity of Care with Designated Care Team Member
- Comprehensive Care Management and Care Planning
- Transitional Care Management
- Coordination with Home- and Community-Based Clinical Service Providers
- 24/7 Access to Address Urgent Needs
- Enhanced Communication (for example, email, or patient portal)
- Advanced Consent

Have you, the patient or the acting health care agent, read the literature on CCM, and agree to participate in CCM services, and understand the following:

- There may be a possible copay (Refer to your insurance card for copay information)
- Patient can cancel the CCM program at any time
- Patient's Care Plan may be shared with other providers
- Only one practitioner per month can bill for the CCM service

Failure to enroll in CCM services prevents the Sequoia Practitioners from managing chronic conditions "in-house," therein leading to a greater chance of requiring out-of-facility appointments with specialists for appropriate management.

☐ **If Medicaid is your primary insurance, CCM services are an uncovered benefit. Please check this box to opt-out.**

Patient Name	DOB
Signature of Patient	Date
Signature of Legal Representative / Relationship	Date

Revised 04/06/2026

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TELEHEALTH URGENT CARE SERVICES
Patient Informed Consent & Acknowledgement

Purpose and Nature of Services

This form is to inform you of Telehealth & Urgent Care Services from Sequoia Integrative Medical Services, LLC ("Sequoia"). Telehealth uses electronic communication (audio/video) to allow healthcare providers in different locations to evaluate, diagnose, treat, and follow up on non-emergency medical conditions. Services may include medical evaluation, treatment recommendations, prescriptions, and care coordination. We may use a secure AI tool to audio record your visit and assist with documentation of your visit. Your provider reviews and approves all notes. You may decline the use of AI in documenting your visits. If you do not want us to use this technology, please advise your provider. Telehealth is not for medical emergencies. If you are experiencing a medical emergency, call 911.

Use of Medical Information

Telehealth may involve sharing the following information securely: Medical records & history, images, audio, video, & data from medical devices. Sequoia uses reasonable safeguards to protect your information in accordance with HIPAA.

Expected Benefits and Possible Limitations & Risks

Benefits may include faster and more convenient access to care, reduced travel, improved efficiency, and access to providers who may not be local.

Possible limitations and risks include technical issues that may interrupt care, Telehealth may not be an appropriate replacement for the type of care needed or an in-person visit or higher level of care many be required in some cases, and there may be unauthorized access to information (despite safeguards).

Patient Rights

- I may refuse or withdraw consent at any time without affecting future care
- I may request in-person services when available
- I may ask questions at any time, and stop a Telehealth or Urgent Care visit at any time.
- I will be informed of anyone present during my visit and may request privacy

Privacy Practices (NPP Acknowledgement)

- I have received or been offered Sequoia's Notice of Privacy Practices.
- My information may be used for treatment, payment, & healthcare operations as permitted by law.

Financial Responsibility

I understand that services may be billed to my insurance and I am responsible for any applicable co-pays, deductibles, or non-covered services.

CONSENT: I have read and understand the information about Telehealth and Urgent Care Services as described above, and I agree to receive such services.

Patient Name	DOB
Signature of Patient	Date
Signature of Legal Representative / Relationship	Date

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REMOTE PATIENT MONITORING CONSENT FORM

RPM services allow your medical provider to monitor your health in between visits. This does not mean your provider will be monitoring your status 24/7. RPM may help your medical provider identify issues that require attention sooner than without RPM and allows you to communicate information to your provider without having to travel to the provider office. RPM devices rely on good cellular or bluetooth connection to transmit data, any deficiencies in connection may result in failure to transmit information.

I agree to allow Sequoia to provide Remote Patient Monitoring (RPM) services. These services include using remote health monitoring technology to wirelessly transfer health data, including, but not limited to blood pressure, weight, blood glucose, etc. RPM also includes consultation and guidance from my medical provider, who will have access to view this data and may communicate with my, or members of, my care team, including family, caregivers, guardians, etc.

I understand that:

- 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 this Remote Patient Monitoring program.
- I can only participate in this program with one medical provider at a time.
- I will take my readings as instructed by my medical provider as part of my participation in the program.
- My data will be electronically transmitted from the device(s) to my provider in a safe and secure manner, but that information security can never be 100% guaranteed.
- My provider will securely and confidentially store my collected data into my electronic medical record to the best of their ability, but information security can never be 100% guaranteed.

I acknowledge that:

- RPM IS NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORING 24/7. Call 911 for immediate medical emergencies.
- By providing phone & email information below, I agree to opt into automated & personalized text messages & phone calls. I understand that I can opt out of the automated reminders to take readings at any time.

Financial Consent:

- My insurance will be charged monthly for this service. Co-payments may apply.
- My medical provider owns the equipment, and I am responsible for returning it when my RPM participation has ended.
- I will not tamper with the equipment and understand that I may be responsible for any fees associated with misuse or loss of the equipment.
- I can withdraw my consent to participate in this program at any time by contacting my medical provider and returning the equipment provided to me.

I, _____, have read and understood the information and consent to participate in the Remote Patient Monitoring (RPM) program, as stated above. I am aware this consent is valid until I withdraw it.

The Remote Patient Monitoring program includes reminders to take health measurements. Automated reminders are only sent if you do not take a reading according to your physician's instructions. You can opt out of automated reminders at any time, but still be contacted about your individual treatment plan from your medical provider.

Patient mobile number: _____ Patient home number: _____

☐ I do not have a mobile phone. ☐ I do not have a home phone. ☐ I would like to opt out of automated texts.

☐ Opt out of automated voicemail reminders (CELL). ☐ Opt out of automated voicemail reminders (HOME).

Patient email address: _____ ☐ I do not have an email address.

Patient Name (Print): _____ DOB: _____

Authorized Person (Print): _____ Relationship: _____

Signature of Patient/Authorized Person: _____ **Date:** _____

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