# CONSENT FORM FOR ECARE HOME MONITORING PROGRAM

PO BOX 3040 SPRING HILL, FL 34611 | 877-867-1351

Clear Spring Health

**Patient Information:**

| Name | DOB |
|---|---|
| | |

We would like to invite you to participate in the eCare Home Monitoring Program. This program will allow us to provide you with better patient care to improve your overall wellness.

**Here are some benefits for being a part of the Remote Patient Monitoring (RPM) Program:**

1. **Faster intervention for problems**
2. **Increased awareness of health status**
3. **More consistent communication with clinical staff**

**What you need to know before you sign up:**

- Your medical provider has requested a minimum of 30 days of consistent monitoring of your health status based on your current health condition(s).
- **Risks or discomforts:** Patients with implantable heart devices should consult their physician prior to using wireless medical devices.
- **Monitoring time:** Participation will take approximately 2 minutes to complete per day.
- **Monitoring location:** All monitoring activities will be done on smart, internet-connected mobile devices.
- **Non-Emergency:** EIn the event of an emergency, CALL 911. We are not responsible for monitoring and/or responding to emergencies while being monitored.

**Privacy Information:**

Results of this monitoring program are stored securely with our HIPAA-compliant vendor. No identifiable information gathered from this program will be shared with any 3rd party organizations without your express written consent.

**Financial Information:**

Participation in this program should involve no cost to you.

**How long will I be on the monitoring program?**

It will depend on your overall health condition. Our nurses, in collaboration with your doctor, will be able to communicate how long you stay on the program. At the end of the monitoring, it will be your responsibility to RETURN all equipment, free of charge, in the provided shipping bag. Also, if participation lags you will be asked to return the equipment. If equipment is not returned, you may be charged a fee.

**Do you have a smart phone or a tablet? Select one.**

☐ iPhone ☐ Android ☐ Tablet ☐ Ninguno

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**Who can I contact if I have questions or concerns about this monitoring program?**

If you have any questions, you may also contact us at:

**eCare Home Monitoring**

**877-867-1351** | ecarehomemonitor@clearspringhealthcare.com

**Who can I contact if I have questions or concerns about the monitoring devices?**

If you have questions about your monitoring devices or need assistance troubleshooting these devices, you may contact our technology partner:

**SynsorMed**

**888-605-1440** | info@synsormed.com

**Consent**

I have read this form and the monitoring program has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the program described above and by signing below consent to its terms and conditions.

| | |
|---|---|
| Participant's Name (printed) | Date |
| Participant's Signature | Preferred Phone Number |
| Relation to Participant | |

☐ **Verbal consent provided by member/representative/POA**

| | | |
|---|---|---|
| Genesys Phone Interaction ID | Date | Time |

Consent to participate in program was verbally provided by member/representative/POA during call (call details above). Consent form was read out to member in its entirety and member verbalized understanding and agreement.

| |
|---|
| Consent obtained by (Full Name and Title) |

**This section to be filled out by eCare Nurse Coordinator only:**

| | | |
|---|---|---|
| Device | Scanned Date | Faxed Date |