PATIENT CONSENT & AGREEMENT

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I, the undersigned patient, of _____(Medical Provider or Group) consent as follows:

My healthcare provider is prescribing a product that includes a remote monitoring component designed to gather and record information including my use of the product (the "RMM Device") with the goal of improving health outcomes by sharing information with my healthcare provider and the DME supplier.

- I understand and agree that I am the only person who should be using the RMM Device provided to me.
- I agree to use the RMM Device as instructed and will not use the RMM Device(s) for any reason other than my own personal health monitoring and as instructed.
- I will not tamper with the RMM Device and understand that I am responsible for any fees associated with misuse of the RMM Device.
- I understand that clinical data will be collected and sent to an electronic database managed by Remote Medical Monitoring, LLC and accessed by my healthcare provider and the DME supplier.
- I consent and agree to my healthcare provider's and the DME supplier's access and use to this information and the inclusion of such information in RMM's electronic databases.
- I understand that the healthcare provider is paid a fee for time spent reviewing and analyzing the data collected.
- I understand that the RMM Device is not an emergency medical device and is not monitored 24/7, and that in case of a medical emergency I should call 911.
- I understand that a RPM Qualified Health Professional will only view my readings periodically, 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 understand that I can withdraw my consent to participate in this program at any time by returning the RMM Device(s) to the DME supplier and signing the RRM withdrawal form which I can obtain from my healthcare provider.
- I understand that information collected prior to my withdrawal from the program will remain in the possession of and is data owned by Remote Medical Monitoring Institute, LLC and its licensees subject to medical privacy laws.
- I understand that (i) RMM is not a healthcare provider (ii) RMM has no responsibility for judgments or decisions related to medical care, diagnosis and treatment, medical record document, and (iii) my healthcare provider is solely responsible for such matters.

I, _____(Print Your Name) have read and understand the information and consent to participate in the Remote Patient Monitoring program as stated above.

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Signature of Patient or Authorized Person Date