ADD LOGO

Patient participation in Self-Measured Blood Pressure Program Loaner Agreement

I understand by participating in the Self-Measured Blood Pressure program, I will be asked to

- Take my blood pressure using the blood pressure device provided to me and as directed.
- Record the blood pressure readings as instructed below.
- Report these readings to primary care provider

Blood pressure device serial number: _____

Anticipated date of return: _____

Blood pressures will be reported back to the primary care provider by (circle one):

1. Telephone
2. Secure computer messaging/patient portal
3. Bring device or log to office
4. Mailed, if mailing, address:

Patient name (print): _____

Patient date of birth: _____Insurance ID_____

Email: _____

Phone Number:(_____)_____Primary Care Provider:_____

By signing this, I agree to the following:

- I agree to participate to the best of my ability by tracking my blood pressure ____ times a week at _____(specify times of day) for ____ weeks/months and submit my results to my primary care provider.
- I will report any blood pressure readings higher than_____ to my primary care provider.
- I will return the blood pressure device to the provider practice on the anticipated return date as listed on this form.
- I understand I may be held financially responsible for any damaged or missing equipment.

Please sign below:

Signed: _____Date: _____

MCD Public Health