USA Security Net Inc.

REGISTRATION FORM

(Please Print and Return Via Fax to: 888-571-8808)

Today's Date _____/_____/_____ Type of service:_____

CLIENT/SUBSCRIBER INFORMATION

Subscriber Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Primary language spoken:	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Home Phone No. ( )	Cellular Phone No. ( )

P.O. Box	City	State	ZIP Code

Call directions if no response after (2) attempts: (Check all that apply.) ❑ CALL ON-SITE SECURITY	❑ CALL CELLULAR PHONE ❑ ON-SITE VISIT ❑ CALL NEIGHBOR/FRIEND ❑ CALL FAMILY MEMBER	E-Mail Address: _____ ❑ PETS Type: _____

THIS IS NOT A TERM CONTRACT; HOWEVER, WE WOULD APPRECIATE A (30) DAY NOTIFICATION OF CANCELLATION. PLEASE NOTIFY US AT: 1-877-421-0280. FAX: 888-571-8808 E-MAIL: info@usasecuritynet.com

LIST THOSE LIVING AT THE SAME ADDRESS BELOW:

Name of Local Friend or Relative	Relationship to Client	Work/Mobile Phone No ( )
Name of Local Friend or Relative	Relationship to Client	Work/Mobile Phone No ( )

KEEP IN MIND WHEN FILLING OUT THE "IN CASE OF EMERGENCY" CALL LIST TO BEGIN WITH LISTING THE FRIEND OR RELATIVE WHO LIVES THE SHORTEST DISTANCE FROM THE CLIENT.

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.
		( )	( )
		( )	( )
		( )	( )
		( )	( )

SUBSCRIBER SERVICES

❑ MEDICAL ALERT SYSTEM: 3600B ❑ $ 299.95 (Purchase no monitoring) ❑ $189.95 (With monitoring service)	❑ LIFESENTRY TWO-WAY VOICE $199.95, 24/7 monitoring required.	Monitoring: ❑ No ❑ Yes ❑ $13.95, billed quarterly in advance.	Wellness Call Only: ❑ Daily $39.95/month ❑ Weekly $21.95/month ❑ Twice Daily $58.95/mo.

Activation Device Water Resistant: ❑ Pendant ❑ 3 in 1 device (clip, wristband, cord)	❑ Long Range $85.00 ❑ wrist	❑pendant ❑black ❑white	❑ 4-Channel Receiver $75 ❑ Remote speaker/microphone $105.00 ❑ Duplex speaker $45.00 ❑ Customer need quote for installation. ❑ Indicate number of devices, use separate sheet, if needed. _____
MEDICAL ALERT SYSTEM: 2400A ❑ $229.95 (Purchase no monitoring)	❑ $99.95 BASIC	❑ Smoke Detector $65	❑ Motion Detector $65 ❑ Door/window $65 ❑ Carbon Monoxide $65

MEDICAL INFORMATION

PRIMARY CARE PHYISICIAN	Office Phone No. ( )	Address of Primary Care Physician:	Pharmacy contact information: ( ) ( ) ❑ Pick up meds ❑ Deliver meds
Do you have other care providers? ❑ Yes ❑ No	Office Phone No. ( )		
Additional Care Providers: NAME	Office Phone No. ( )	Address: Street, City, State, Zip	Emergency Call Phone No. ( )

DAILY MEDICATIONS? ❑ No ❑ Yes, list below:
❑ PREFER NOT TO LIST ❑ List attached.
(Obtain list from pharmacy or physician.)

Name of medication	Dose	Use

MEDS Set-up: ❑ SELF ❑ OTHERS
❑ PILL BOX? ❑ Yes ❑ No

ALLERGIES? ❑ No known allergies ❑ Yes, then list below:

SPECIAL NEEDS? *Please detail below:*

MEALS DELIVERED? ❑ No ❑ Yes
If, yes, then delivered by: _____
Frequency: ❑ Daily ❑ Weekly ❑ When Ordered
Provide contact information: Phone No. ( ) _____

Daily TREATMENTS? ❑ No ❑ Yes	❑ Oxygen	❑ Inhaler ❑ Hearing Aides: ❑ Left ❑ Right ❑ Both	❑ Humidifier	❑ Contacts	Dentures? ❑ No ❑ Yes
❑ Physical Therapy	❑ Enema		❑ Aspirator	❑ Eye Glasses	❑ upper ❑ lower ❑ both

Medical Alert ID Jewelry: ❑ No ❑ Yes ❑ Blood Type _____ Recent Hospital stay? ❑ No ❑ Yes

Walking assistance? ❑ No ❑ Yes
❑ Wheel Chair ❑ Motorized Wheel Chair

Diabetes? ❑ No ❑ Yes, then: ❑ Meter ❑ Stick checks ❑ Insulin ❑ Pills ❑ Both Pills and Insulin ❑ Insulin pump

❑ Cane/Walker ❑ Prosthesis type: ❑Leg ❑Arm

Call Reminder Services: ❑ Daily ❑ Weekly ❑ Monthly ❑ Wellness Call (Nurse)

❑ In-Home Care ❑ Medication Reminders ❑ Medical Appointments ❑ Transportation ❑ Other

The above information is true to the best of my knowledge. I will advise USA SECURITY NET, Inc. of any changes. I understand that USA SECURITY NET, Inc. will periodically send out requests for data updates. This information will remain the sole property of USA SECURITY NET, Inc. and WILL NOT BE SHARED WITH ANY OTHER AGENCY.

X _____
CLIENT SUBSCRIBER/GUARDIAN SIGNATURE DATE

HIPAA Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **USA SECURITY NET INC.** to use and/or disclose certain protected health information (PHI) about me to medical emergency responders.

This authorization permits **USA SECURITY NET INC.** to use and/or disclose the following individually identifiable health information about me, provided within the "Subscriber Data Form 2010".

The information will be used or disclosed for the following purpose: *At the request of the service subscriber for purposes of monitoring and dispatching emergency responders.*

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on the date I terminate my service with **USA SECURITY NET INC.**

USA SECURITY NET INC. will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive service from **USA SECURITY NET INC.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **USA SECURITY NET INC.** has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **USA SECURITY NET INC.**
5445 DTC Parkway, Penthouse 4, Greenwood Village, CO 80111

Signed by: _____ _____
Signature of Subscriber or Legal Guardian Relationship to Subscriber

_____ _____
Print Subscriber's Name Date

_____
Print Legal Guardian's Name

Patient/guardian must be provided with a signed copy of this authorization form.