PRISM HEALTH SERVICES, LLC.
Be Home, Be Safe, Be Happy.

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Information Needed to Activate MedReady Online

UNIT ID #:				
Organization Name: _____ Contact Person: _____				
Organization Address: _____				
Organization Main Phone Number: _____ Organization Fax Number: _____				
Organization Email Address: _____Organization Website: _____				
**********				
Patient Name:				
Street Address:				
City : State: Zip Code:				
Time Zone: (*Circle one*):	Eastern (EST)	Central (CST)	Mountain (MST)	Pacific (PST)
**********				

PREFERENCES: Call Back log: **Please write legibly**

#	**NAME OF PERSON** *(First , Last Name)*	**RELATIONSHIP** (*To the client)*	**PHONE #** (*# which will receive text / phone)*	**Email** (*Most frequently checked email please)*	**Preference** *(Pls. Indicate priority 1,2,3,)*
1					( )EMAIL ( )SMS (text) ( )Phone
2					( )EMAIL ( )SMS (text) ( )Phone
3					( )EMAIL ( )SMS (text) ( )Phone
**********					

Agreement & Consent

I _____the undersigned take the responsibility of this device on behalf of my loved one _____ *(Name of the person for whom the device is being used)*.

I understand that I will be receiving the phone calls / text messages / emails when my _____ (*relationship*) does not take her medication in a timely manner which is indicative of he / she needing assistance. It is my responsibility to acknowledge the message and deploy the necessary help for my loved one to ensure his / her safety and wellbeing.

I understand that Prism Health Services, LLC is a provider of the device and involved with supply / setup only and will not be responsible for any additional care related issues for my loved one. I will pay the invoices as agreed including monthly monitoring fee if indicated.

_____ _____ _____

Signature of Responsible Party Date Printed Name of Responsible Party