

DOCUBANK[®] HEALTHCARE DIRECTIVE REGISTRY ENROLLMENT FORM

A. MEMBER INFORMATION Information in **BOLD** appears on your card. *Email address is required for online account access.

Prefix: Name:	Home Phone:
Address:	Work Phone:
City, State, Zip:	Email Address*:
	DOB (optional):
Trust Name and Creation Date (Optional. 57 character max, to appear on your card):	
Attorney: Roxanne Sher Olson, Esq.	Firm name: Law Offices of Roxanne Olson

B. SERVICE SELECTION One Year **\$55** Five Years **\$175**

C. PAYMENT METHOD Paid through Attorney Credit Card Check (payable to DocuBank)

Credit Card Number _____ Exp Date _____
 Name on Credit Card _____ Card Type _____

D. EMERGENCY CONTACTS (Optional) If information is not available now you can call us to update after you receive your card.

FIRST CONTACT		PHYSICIAN	
Name:	Relationship:	Name:	
Home #:	Work #:	Phone:	
Cell #:	Email:	First Contact Note:	
SECOND CONTACT		THIRD CONTACT	
Name:	Relationship:	Name:	Relationship:
Home #:	Work #:	Home #:	Work #:
Cell #:	Email:	Cell #:	Email:

E. OPTIONAL CARD INFO Please number up to 4 selections. (All selections may not fit on your card.)

Allergies Penicillin Sulfa Latex Peanuts _____ _____ _____

Permanent Medical Conditions (Do **not** list medications here. See section F.)

Alzheimer's Arthritis Asthma Diabetes Heart Disease High Blood Pressure
 Cancer survivor _____ (type) Stroke history _____ _____

Card Note (45 char. max) _____ (omitted if storing medication list, see section F)

F. MEDICATION LIST (Optional) You can store a list of your medications. Because medications may change frequently, there is an additional fee at time of renewal. **Is a Medication List (signed and dated) included?** Yes No

G. MEMBER STATEMENT I have completed an advance directive document(s) (e.g. living will, health care power of attorney, HIPAA authorization, and/or organ donation information) of my own free will and have chosen to enroll in DocuBank to help make my document(s) available when requested. To ensure prompt access, I authorize that my document(s), emergency contact and health information stored with DocuBank be accessible to anyone who provides the member number and PIN on my card. I will notify DocuBank promptly of changes in any of my stored information, and also of the revocation or replacement of my document(s). I understand that DocuBank is not responsible for the validity or accuracy of any information stored by DocuBank, including the health information that also appears on my card. I understand that: by accepting my card I have verified and confirmed the accuracy of all information on the card before carrying it; by providing a fax number for my physician, I am granting DocuBank permission to fax an enrollment notification enabling this physician to obtain my directives; that DocuBank does not provide legal advice; and that I may cancel this service in writing by written request to DocuBank.

Check 1 or none:

- I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment and whenever my documents are requested.
- I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment only.

Signature: _____ Date: _____