LEGAL DIRECTIVES ENROLLMENT FORM

LEGALDIRECTIVES, LLC

To enroll: Complete this form and mail it with your payment and a clear copy of your living will, health care power of attorney, HIPAA Authorization form to: Legal Directives, LLC, P.O. Box 1798, Matthews, NC 28106 OR fax this form along with your documents to 1-866-363-4895.

Personal Information (Please print clearly)

Name: First _____ Middle _____ Last _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____)_____ **Cell Phone** (_____)_____

Email: _____ **Date of Birth:** _____

Mother's Maiden Name: _____ *(for private website access to update your personal information)*

Allergies: _____

Medical Conditions: _____

_____

Emergency Contacts These will be provided to hospital staff when your directives are requested.

1. **Name:** _____ **Relationship:** _____

   Home Phone: (_____)_____ **Work Phone:** (_____)_____ Cell: (_____)_____

2. **Name:** _____ **Relationship:** _____

   Home Phone: (_____)_____ **Work Phone:** (_____)_____ Cell: (_____)_____

Primary Care Physician: _____

Phone: (_____)_____ **Fax:** (_____)_____ **Name of the Practice:** _____

□ Please fax a copy of my Legal Directives to my Primary Care Physician

Membership Information

Please tell us how many years you would like to enroll. At the end of your initial term, you will receive a renewal notification in the mail allowing you to renew your membership.

Subscription Length: □ One year $30 □ Two years $48 □ Five years $95

Method of Payment: □ Check or money order payable to Legal Directives, LLC

□ MasterCard □ Visa □ Discover □ American Express

Card Number: _____ **Exp. Date:** _____ **Name on Card:** _____

Billing Address (if different from above):_____

Registration & Certification: I request that Legal Directives, LLC electronically store a copy of my attached documents and provide a copy of the stored documents to my physician listed on this form and to any health care provider or other user who requests them for my care. I certify that the information supplied to Legal Directives, LLC is correct and that the attached documents are my current health care legal documents and information. I agree to immediately notify Legal Directives, LLC, in writing, in the event of my revocation of the attached documents or of any information contained in my file or my desire to terminate this service. I will indemnify and hold harmless Legal Directives, LLC for any damages resulting from its reliance on these certifications or on any inaccurate information I supplied or for any unauthorized use of this service. I agree to safeguard my wallet card from unauthorized access. I understand that anyone who gains access to my card can use it to gain access to my documents and personal information and I will not hold Legal Directives, LLC responsible for such unauthorized access.

Signature: _____ Date: _____ / _____ / _____