



LEGALDIRECTIVES, LLC

# LEGAL DIRECTIVES ENROLLMENT FORM

**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, PO Box 1798, Matthews, NC 28106 OR fax this form along with your documents to 1-866-363-4895 OR email this form to enroll@legaldirectives.com.

## Person Information (Please print clearly)

**Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

**Mailing Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ **Work 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:** \_\_\_\_\_

## Membership Source

Please tell us from whom you received this brochure

**Name:** \_\_\_\_\_ **Company/Organization:** \_\_\_\_\_

**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): \_\_\_\_\_

Please automatically renew my membership when due and bill my credit card

**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. I will not hold Legal Directives, LLC responsible for any situation where the emergency service is not correctly utilized for my benefit.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_