**DocuBank Enrollment Form ElderCounsel**

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| **MEMBER INFORMATION** *Email address is required for online access and medication list.* |
| Name:  | DOB:  |
| Address:  | Primary Phone:  |
|  | Alternate Phone:  |
| City, State, Zip:  |
| Email Address:  |
| Trust Name: (54 character max) |

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| **FIRM INFORMATION** *Name of Attorney and/or firm providing this membership.* |
| Firm Name: **Elder Law & Life Care Planning Center** | Attorney Name: **Helayne Levy Payne** |

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| **PAYMENT INFORMATION**  |

 **Initial Membership Length:** (select only one)❑ 1 year ❑ 5 years

 Payment Method: ❑ Attorney ❑ Check ❑ Credit Card (see details below)

 CC#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp:\_\_\_\_\_\_ Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CSV:\_\_\_\_\_

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| **EMERGENCY CONTACTS** *(Optional) Information can be added or updated when you receive your card. Information in bold is on the card.* |
| Primary Contact:  | Relationship:  | Email:  |
| Home #:  | Work #:  | Cell #:  | Note:  |

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| Second Contact:  | Cell:  | Email:  |

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| Third Contact:  | Cell:  | Email:  |

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| **MEDICAL INFORMATION** *If fax number is provided for physician, doctor may receive a fax with your access information.* |
| Physician Name:   | Phone:  | Fax:   |

 **Medical Allergies** *(Optional)* *Allergies will appear on your card for quick reference by physicians. There is a 45 character limit.*
 ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Peanuts ❑ Shellfish ❑ Aspirin ❑ Tree Nuts ❑ Eggs ❑ Naproxen

 ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Permanent Medical Conditions** *(Optional) There is a 45 character limit. Do NOT list medications here.*

 ❑ Arthritis ❑ Asthma ❑ Heart Disease ❑ High Blood Pressure ❑ Low Vision ❑ Hearing Loss
 ❑ Cancer (type)\_\_\_\_\_\_\_\_\_\_\_\_\_ (stage)\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Additional Card Note** *(45 char. max)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medication List Included** *(Optional) If yes, a note will appear on your card.* ***Add*** *one now or* ***online at any time***. ❑ Yes ❑ No

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| **MEMBER STATEMENT** *And optional alerts for emergency contacts* |

 I have chosen to enroll myself in DocuBank to help make personal emergency information available promptly. 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 the DocuBank member card. All advance directives have been completed of my own free will and I will notify DocuBank promptly of changes in any of the stored information, and also of the revocation or replacement of any 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 the member card; by accepting a card I have verified and confirmed the accuracy of all information on the card before carrying or distributing it; by providing an email address I am authorizing DocuBank to email me; 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; I am granting DocuBank permission to alert my contacts as indicated on this form; if I provide an email address for the emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with member information as indicated by my selection of such permission below. I understand that my DocuBank membership includes the optional use of the DocuBank SAFE, which provides online access to my personal documents. I understand that DocuBank does not provide legal advice; and that I may cancel this service at any time by written request to DocuBank.

 **Emergency Contact Alerts** (Check 1 or none) Alerts will be sent to all contacts for whom you have provided an email address.

 ❑Please use the email address(es) provided above to **send an email introducing my emergency contact(s) to DocuBank**
 **and please send an alert email to the same contact(s) whenever my card is used**.

 ❑Pleaseuse the email addresses provided above to **send an email introducing my emergency contacts to DocuBank**.

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

1. **DO NOT DELETE this paragraph -- it is hidden text and will not print. To add content to the end of this document, do so by placing your cursor at the end of the above paragraph (before the paragraph mark) and pressing ENTER to start a new paragraph. DO NOT DELETE the Section Break adjacent to this paragraph; it is there to help the footer maintain its format.**