DOYLE LAW PC
Peace of Mind Planning℠

How to Order Your DocuBank® Service

- Complete and sign the DocuBank® Healthcare Directive Registry Enrollment Form (a married couple who wants to enroll both spouses will have to prepare a separate form for each spouse).

- To include a list of your current medications, complete and sign the DocuBank® Medication List (a married couple who wants to include a list for both spouses will have to prepare a separate medication list for each spouse).

- Send your enrollment form (and medication list), a copy of your executed Power of Attorney for Health Care, and payment to DocuBank® at: PO Box 325 Narberth PA 19072.

- If paying by credit card, you can send to DocuBank® via email (attorneyenrolls@docubank.com) or fax (610-667-9726). Be sure to scan and send both sides of the enrollment form if you have included a medication list.

  Note: as a Doyle Law PC client, you are receiving the initial DocuBank® service at our discounted rates - 1 year for $25 (normally $55) or 5 years at $75 (normally $175). You will be contacted by DocuBank® with renewal rates when your membership is up for renewal.

  DOCUBANK IS NOT A SERVICE OF DOYLE LAW PC, AND NO WARRANTIES, REPRESENTATIONS OR ENDORESEMENTS ARE MADE BY DOYLE LAW PC ABOUT DOCUBANK OR ANY OF ITS SERVICES.

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:	Firm name: **DOYLE LAW PC**

B. Service Selection ☐ One Year **$25** ☐ Five Years **$75**

C. Payment Method ☐ Check *(payable to DocuBank)* ☐ Credit Card

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** (*if fax# is provided, a fax may be sent to Dr.)

Name:	Relationship:	Name:	
Home #:	**Work #:**	Phone:	Fax*:
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)* _____

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. health care power of attorney) 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 if I provide an email address for my emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with my member information; that DocuBank does not provide legal advice; and that I may cancel this service in writing at any time by written request to DocuBank.

Optional Alerts: 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: _____

DocuBank Medication List Storage

Medication	Dosage	Frequency

Member Name: _____

Email Address: _____

Please Sign:_____

Today's Date: _____