PERSONALIZED CARE MEMBERSHIP AGREEMENT

THIS PERSONALIZED CARE MEMBERSHIP AGREEMENT (this "**Agreement**") is made effective as of _____ ____, by and between the **undersigned member** and, if applicable, **additional members** listed on Schedule 1 hereto (each, a "**Program Member**"), and **Lemire Family Practice** a Florida professional limited liability company, having an address of 11115 SW 93rd Court Rd, #600, Ocala FL 34481 ("**Personalized Care Practice**"; and together with Program Member(s), the "**Parties**"). In consideration of the mutual promises and undertakings set forth below and for other valuable consideration, receipt and sufficiency of which are hereby acknowledged by the Parties, and intending to be legally bound, the Parties hereby mutually agree, as follows:

1. **Terms of Services; Program Services.** The Terms and Conditions attached hereto as Exhibit A (the "**Terms**") are incorporated herein and made a part of this Agreement by this reference. The Parties have read and agree to fully comply with the Terms. In consideration of the Member Amenities Fee (as defined below), Personalized Care Practice agrees to designate a physician to provide Program Member with the services and amenities, which are not covered by your health plan or any federal government program, as specifically described in the Terms (the "**Program Services**") in accordance with and as provided by this Agreement and the Terms. Payment of the Member Amenities Fee is not a condition for you to receive any professional medical services that are covered by your health plan or a federally-funded governmental program.
2. **Program Member Information; Additional Program Members.** Program Member represents and warrants that his/her information set forth below is accurate and complete, and agrees to promptly notify Personalized Care Practice of any changes. The information for the additional Program Members, if any, is set forth in Schedule 1, is accurate and complete, and will be updated promptly in writing if and when changed.

A. MEMBER NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

3. **HIPAA Release/Consent.** Program Member agrees, consents and authorizes Personalized Care Practice to disclose all of his/her protected medical information to Signature MD, Inc., in accordance with the Authorization Form accompanying this Agreement as Exhibit B (the "**Authorization**"), in order to facilitate and administer the Personalized Care Practice and Program Services. Simultaneously with execution of this Agreement, Program Member will sign and deliver the Authorization to Personalized Care Practice.
4. **Membership Amenities Fee.** Program Member hereby selects the payment terms for the Program Services ("**Member Amenities Fee**") as indicated below and shall pay Member Amenities Fee in full in accordance with the terms. No part of the Member Amenities Fee paid by Program Member hereunder is being paid in consideration for any medical services covered by Program Member's insurer, health plan or by any governmental program, including Medicare.

ANNUAL MEMBER AMENITIES FEES	
(*Prepaid)	**(*Quarterly Installments)**
☐ Each individual $1650 (annually)	☐ Individual $1800 annual ($450 per quarter)
☐ Two (2) adult individuals $3100 (annually)	☐ Two (2) adult individuals $3400 ($850 per quarter)
☐ Third (3rd) additional adult individual $1400 (annually)	☐ Third (3rd) additional adult individual $1600 ($400 per quarter)

ADDITIONAL NOTES	

5. **Payment Authorization; Execution.** Program Member either (i) tenders together with this Agreement the Member Amenities Fee, or (ii) hereby authorizes Personalized Care Practice's designee to bill one-fourth (1/4) of the Personalized Care Fee (that is, $_____) per calendar quarter (3 months) payable in advance to Program Member's:

CREDIT/DEBIT CARD	☐ Visa	☐ MC	☐ Discover	☐ AMEX	CARD NO.	
CARDHOLDER'S NAME			EXPIRES		VERIFICATION #	

Program Member understands that credit card payments will be processed by Signature MD, Inc. and agrees to make payments by check payable to "***SignatureMD***".

This Agreement, including the attachments and exhibits, will be fully binding upon each Party and constitutes the entire agreement between the Parties in connection with the subject matter in this Agreement, and supersedes all prior agreements and understandings between the Parties, whether written or oral, which have been made before the execution of this Agreement.

Program Member

_____ (Signature)

_____ (Print Name)

Lemire Family Practice Professional Limited Liability Corp

_____

By: James E. Lemire, President

SCHEDULE 1 TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Additional Program Members (James E. Lemire, MD)

A. 2ND MEMBER'S NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

F. ACKNOWLEDGED AND AGREED
INITIALS:

A. 3RD MEMBER'S NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

F. ACKNOWLEDGED AND AGREED
INITIALS:

A. 4TH MEMBER'S NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

F. ACKNOWLEDGED AND AGREED
INITIALS:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, I hereby authorize and direct the use or disclosure of certain information pertaining to me, my health or my health care that is maintained by Lemire Clinic (the "Entity").

1. This Authorization concerns the following medical information about me: demographic information including but not limited to age, address, phone number, email address, name of insurer.

2. This information may be used or disclosed by the Entity to SignatureMD, Entity's Business Associate (as defined under HIPAA).

3. This authorization automatically expires after the termination, for any reason, of my Concierge Medicine Membership Agreement with the Entity.

4. The purpose(s) of this use or disclosure is: At my individual request, in order to facilitate and help administer concierge medical services between me and the Entity.

5. I understand that at any time I have the right to revoke this Authorization pursuant to the Entity's Notice of Privacy Practices, except to the extent that the Entity has already acted in reliance on the Authorization. I understand that I may revoke this Authorization by contacting the Entity.

6. I understand that once information leaves the Entity, the Entity no longer directly controls the information.

7. I understand that the Entity is prohibited from requiring that I sign this Authorization as a condition of my enrollment or eligibility for benefits, except if the Authorization is specifically related to the individual's enrollment or eligibility, or for the Entity's underwriting or risk rating determinations.

Acknowledged and agreed:

1. Print Patient's Name	*Signature of Patient or Patient's Representative*	*Date*
2. Print Patient's Name	*Signature of Patient or Patient's Representative*	*Date*
3. Print Patient's Name	*Signature of Patient or Patient's Representative*	*Date*
4. Print Patient's Name	*Signature of Patient or Patient's Representative*	*Date*

James E. Lemire, MD	*Date*

If by and through a representative of a Patient

My authority to sign this Authorization and agree to the terms herein exists because I am:

(Describe relationship to Patient, or source of authority to sign on Patient's behalf)