SignatureMD Concierge Services
Patient Membership Agreement

This Concierge Service Patient Membership Agreement (the "Agreement") is entered into between individual whose name appears opposite "Member's Name" below and whose signature appears at the end of this Agreement (Member) and SignatureMD, Inc., a California corporation (SignatureMD), and is effective as of the latter of September 15, 2011 and the date appearing opposite the signature of SignatureMD at the end of this Agreement.

1. Member acknowledges that Member has read and accepts the SignatureMD Concierge Services Terms and Conditions (May 19, 2010) which will govern the relationship between Member and SignatureMD pursuant to this Agreement. Such Terms and Conditions are incorporated into and made a part of this Agreement by this reference.

2. Member represents and warrants that the following information regarding Member is accurate at the time submitted to SignatureMD:

1a. MEMBERS NAME	D.O.B	1b. ADDITIONAL SECOND MEMBER	D.O.B.
	/ /		/ /
1c. ADDITIONAL THIRD MEMBER	D.O.B.	1d. ADDITIONAL FOURTH MEMBER	D.O.B.
	/ /		/ /

2. MAILING ADDRESS	CITY	STATE	ZIP CODE

3a. HOME PHONE	3b. OFFICE	3c. MOBILE	3d. FAX
4. E-MAIL ADDRESS			

Designated SignatureMD Program Primary Physician: **ROBERT V. BLAKEBURN, M.D.**

3. Member hereby selects the payment terms for the SignatureMD Concierge Services Program that Member has checked below:

	DISCOUNTED PREPAID BY DEBIT, CREDIT OR CHECK		DEBIT OR CREDIT CARD INSTALLMENTS
	Individual $1,500 annual		Individual $1,600 annual [$400 per quarter]
	Couple $2,800 annual		Couple $3,000 annual [$750 per quarter]
	Additional (3rd) Adult $1,050 annual		Add. (3rd) Adult $1,200 annual [$300 per quarter]

Additional Contract Notes: [Doctor's Office Only] _____

4. Member either (i) tenders to Signature MD with this Agreement the annual fee for the Program selected by Member or (ii) hereby authorize SignatureMD to bill one-fourth (1/4) of such annual fee (or $_____) per quarter (3 months) payable in advance to Member's

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

X _____
Member Signature

_____
Date

By _____
SignatureMD, Inc.

_____
Date