CONCIERGE SERVICES MEMBERSHIP AGREEMENT

THIS CONCIERGE SERVICES 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 St. Louis Personalized Care, LLC, a Missouri Corporation, ("**Physician**"; 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 Membership Fee (as defined below), Physician agrees to provide Program Member with the services and amenities described in the Terms (the "**Program Services**") in accordance with and as provided by this Agreement and the Terms.

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 Physician or Physician's designee 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 Physician 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 Concierge Practice and Program Services. Simultaneously with execution of this Agreement, Program Member will sign and deliver the Authorization to Physician.

4. **Membership Fees.** Program Member hereby selects the payment terms for the Program Services ("**Membership Fee**") as indicated below and shall pay Membership Fees in full in accordance with the terms. No part of the Membership 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.

DISCOUNTED PREPAID BY DEBIT, CREDIT, OR CHECK		DEBIT OR CREDIT CARD INSTALLMENTS	
	Individual $2,000 annual		Individual $2,200 annual ($550 per quarter)
	Two Adults $3,800 annual		Two Adults $4,200 annual ($1050 per quarter)
	Additional 3rd Adult $1,600 annual		Additional 3rd Adult $1,700 annual ($425 per quarter)

ADDITIONAL NOTES	

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

CREDIT/DEBIT CARD		Visa		MC		Discover		AMEX	CARDHOLDER NAME			
CARD NUMBER									**EXPIRATION**		**CC ZIP CODE**	

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

______________________________	______________________________
Program Member Signature	*Robert J. Saltman, M.D.*
Date: ______________________	Date: ______________________

SCHEDULE 1 to MEMBERSHIP AGREEMENT
ADDITIONAL PROGRAM MEMBERS

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:				

Consent for Communications by SignatureMD or Personalized Care Practice and Designated Physician

By signing this consent, I hereby authorize SignatureMD, Personalized Care Practice and/or Designated Physician to contact me by phone, mail, email, phone, and /or text message, including through the use of automated technology and prerecorded messages, for any communications, including but not limited to communications about my care, the Personalized Care Practice, any Program Services, payment for my care, or the products and services SignatureMD provides, including marketing and informational communications at the contact information I provided to SignatureMD above. I understand that consent is not required to receive services from SignatureMD. I can opt out of receiving marketing communications from SignatureMD or Personalized Care Practice as provided in SignatureMD's Privacy Policy. I can also text back "STOP" if I no longer wish to receive text messages.

By signing below, I acknowledge my understanding of the inherent risks of communicating via unencrypted email and hereby consent to receive such communications despite those risks. By signing below, I also acknowledge that you have the choice to receive communications via other more secure means. By signing below, I agree to hold SignatureMD, Personalized Care Practice and Designated Physician harmless for unauthorized use, disclosure, or access of information sent to the email address I provide.

With this consent, I waive any claim I may have under federal or state law, including but not limited to the Telephone Consumer Protection Act, 47 U.S.C. § 227 and its implementing regulations, against SignatureMD, Personalized Care Practice and Designated Physician for the making of such calls and text messages.

1st Member Printed Name	Signature of Patient or Representative	Date
2nd Member Printed Name	Signature of Patient or Representative	Date
3rd Member Printed Name	Signature of Patient or Representative	Date
4th Member Printed Name	Signature of Patient or Representative	Date
Robert J. Saltman, MD	Date	

If by and through a representative of a Patient

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

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