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 About Women's Health Medical Group, Inc., a California 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 demographic protected health 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 $2,500 annual		Individual $2,700 annual ($675 per quarter)
	Two Adults $4,750 annual		Two Adults $5,100 annual ($1,275 per quarter)
	Additional 3rd Adult $2,000 annual		Additional 3rd Adult $2,100 annual ($525 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   *Catherine A. Grellet, 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:					