SignatureMD Concierge Services

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 December 1, 2012 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. MEMBER 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: **LISA C. CAPALDINI, 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 $2,000 annual		Individual $2,200 annual [$550 per quarter]
	Two Adults $3,800 annual		Two Adults $4,200 annual [$1050 per quarter]
	Additional Third Adult $1,600 annual		Additional Third Adult $1,800 annual [$450 per quarter]

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

4. Member either (i) tenders to SignatureMD 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 (**IMPORTANT:** If you are paying by CHECK, please make checks payable to: "SignatureMD")

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

X _____
Member Signature

_____
Date

By _____
Signature MD, Inc.

_____
Date

[a] 4640 Admiralty Way, Suite 410 Marina del Rey, CA 90292
[p] 866 883 8859 [f] 310 564 1773 [w] www.signatureMD.com

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 Lisa Capaldini, MD (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 Lisa Capaldini, MD 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 individual name in Section 2 above.

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:

Print Patient's Name	*Date*
Signature of Patient or Patient's Representative	*Entity Co-Signature*

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)