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 Advanced Health and Wellness, LLC an Ohio 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 $1,650 annual		Individual $1,800 annual ($450 per quarter)
	Two Adults $3,000 annual		Two Adults $3,400 annual ($850 per quarter)
	Additional Adult(s) $1,000 annual per adult		Additional Adult(s) $1,200 annual per adult ($300 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

Date: _____

Joseph Stubbers, DO

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:

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 Fairfield Primary Care Inc. (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 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:

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*

Entity Co-Signature	*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)