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 February 01, 2009 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.
	/ /		/ /

2. MAILING ADDRESS	CITY	STATE	ZIP CODE

3a. HOME PHONE	3b. MOBILE	4. E-MAIL ADDRESS

Designated SignatureMD Program Primary Physician: **Doug Pitman, MD**

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

	DEBIT OR CREDIT CARD INSTALLMENTS		DISCOUNTED PREPAID BY DEBIT, CREDIT OR CHECK
☐	Individual $2,100 annual [$525 per quarter]	☐	Individual $1,900 annual
☐	Couple $3,600 annual [$900 per quarter]	☐	Couple $3,400 annual
☐	Individual $1,500 half-year [$375 per quarter]	☐	Individual $1,300 half-year
☐	Couple $2,700 half-year [$675 per quarter]	☐	Couple $2,500 half-year
☐	**N/A**	☐	Scholarship $1,100 annual
☐	**Total Amount $_____per quarter**	☐	**Total Amount $_____annual**

Contract Notes: _____

Please make all checks payable to SignatureMD, Inc.

4. Member either (i) tenders to Signature MD with this Agreement the annual fee for the Program selected by Member or (ii) hereby authorizes SignatureMD payable in advance to Member's (please select one):

Credit or Debit Card

Cardholder Name | Card Number | Expiration | CVV | Card Zip Code

eCheck (ACH)

Bank Routing Number | Bank Account Number | ☐ Checking ☐ Savings Account Type

X _____ By _____

Member Signature | SignatureMD, Inc.

_____ _____

Date | Date

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
Doug Pitman, 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)