Personalized Care Program Agreement

SignatureMD
Human. Health. Care.

This **Personalized Care Program Agreement** (this "Agreement") is made effective as of _____, (the "Effective Date") by and between the undersigned member and, if applicable, additional members listed in Schedule 1 to this Agreement (each, a "Program Member"), and LE&A PC-EHRLICH, PLLC, an individual, having an address of 2535 Kirby Drive, Second Floor, Houston, TX 77019 ("Personalized Care Practice"; 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 of Service 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 Amenities Fee (as defined below), Personalized Care Practice agrees to designate a doctor to provide Program Member with the services and amenities, which are not covered by your health plan or any federal government program, as specifically described in the Terms (the "Program Services") in accordance with and as provided by this Agreement and the Terms. Payment of the Amenities Fee is not a condition for you to receive any professional medical services that are covered by your health plan or a federally-funded governmental program.

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 Personalized Care Practice of any changes. The information for the additional Program Members, if any, is set forth in Schedule 1 to this Agreement, is accurate and complete, and will be updated promptly in writing if and when changed.

Program Member Name	Date of Birth	Email Address

Home Phone	Cell Phone	Office Phone	Fax

Mailing Address	City	State	Zip Code

3. HIPAA Release/Consent. Program Member agrees, consents and authorizes Personalized Care Practice to disclose all of his/her demographic non-medical information to Signature MD, Inc., in accordance with the Authorization Form in Schedule 1 to this Agreement (the "Authorization"), in order to facilitate and administer the Personalized Care Practice and Program Services. Simultaneously with execution of this Agreement, Program Member will sign and deliver the Authorization to Personalized Care Practice.

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

Annual Amenities Fees

Annual Prepaid	☐ Individual $2,200 (Prepaid)	**Quarterly Installments**	☐ Individual: $2,400 ($600 Quarterly Installments)
	☐ Second Individual: $2,200 (Prepaid)**		☐ Second Individual: $2,400 ($600 Quarterly Installments)
	☐ Each Additional Individual: $2,200 (Prepaid)**		☐ Each Additional Individual $2,400 ($600 Quarterly Installments)

Notes

**Additional Program Member discounts will be allocated equally amongst all Program Members.

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

Credit or Debit Card

Cardholder Name	Card Number	Expiration	CVV	Card Zip Code

eCheck (ACH)

Bank Routing Number	Bank Account Number	Account Type
		☐ Checking ☐ Saving

Program Member understands that credit card payments will be processed by Signature MD, Inc. and agrees to make payments by check payable to "LE&A PC-Ehrlich, PLLC"; c/o SignatureMD, 6001 Broken Sound Pkwy NW, Suite 340, Boca Raton, Florida 33487.

This Agreement, including the attachments and exhibits, will be fully binding upon each Party and constitutes the entire agreement between the Parties in connection with the subject matter in this Agreement, and supersedes all prior agreements and understandings between the Parties, whether written or oral, which have been made before the execution of this Agreement.

Program Member

Signature: _____

Print Name: _____

LE&A PC-EHRLICH, PLLC

_____

Lisa L. Ehrlich, M.D.

Schedule 1 to Personalized Care Program Agreement

Additional Program Members

Program Member Name from Personalized Care Program Agreement

Acknowledged and Agreed (Initials)

2nd Program Member

Program Member Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

3rd Program Member

Program Member Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

4th Program Member

Program Member Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

Authorization for Release of Protected Health Information

By signing this Authorization, I hereby authorize and direct the use or disclosure of certain demographic non-medical information pertaining to me that is maintained by LE&A PC-EHRLICH, PLLC (the "Entity").

1. This Authorization concerns the following non-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 Personalized Care Program 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 personalized care Program Services between me and the Entity and for the marketing activities and communications of SignatureMD and/or 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 Entity.
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 for specific exceptions not applicable here.

1st Program Member Printed Name	Signature of Patient or Representative	Date
2nd Program Member Printed Name	Signature of Patient or Representative	Date
3rd Program Member Printed Name	Signature of Patient or Representative	Date
4th Program Member Printed Name	Signature of Patient or Representative	Date
LISA EHRLICH, M.D.	Date	

If by and through a representative of a Program Member

My authority to sign this Authorization and agree to the Terms herein exists because I am:

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

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 electronic communication platforms and hereby consent to receive such communications despite those risks. By signing below, I also acknowledge that I 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 or exchanged with the email address or sent to or exchanged with other electronic communication contact information 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, text messages and any other electronic communications.

1st Program Member Printed Name	Signature of Patient or Representative	Date
2nd Program Member Printed Name	Signature of Patient or Representative	Date
3rd Program Member Printed Name	Signature of Patient or Representative	Date
4th Program Member Printed Name	Signature of Patient or Representative	Date
LISA EHRLICH, M.D.	Date	

If by and through a representative of a Program Member

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

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