Completing the Member Paperwork

Welcome To The SignatureMD Family

Please take your time and fill out the following Member Agreement. This agreement can be completed and given back to your physician the following ways:

- Complete a hard copy of the agreement, sign it, and fax it to the physician's office at (208) 773-9764.
- Complete a hard copy of the agreement, sign it, scan it and email it to the SignatureMD Patient Liaison at jlove@signaturemd.com
- Complete a hard copy of the agreement, sign it, and mail it to the physician's office at

  Dr. Lawrence K. Gibbon
  185 W. 4th Ave., suite B
  Post Falls, ID 83854

- If you are paying by check, please make checks payable to Signature MD

PERSONALIZED CARE MEMBERSHIP AGREEMENT

THIS PERSONALIZED CARE MEMBERSHIP AGREEMENT (this "Agreement") is made effective as of the Effective Date (as defined below in Section 1), by and between the undersigned member and, if applicable, additional members listed on Schedule 1 hereto (each, a "Program Member"), and Riverview Personalized Care, LLC, a limited liability corporation, with the principal place of business at 185 W. 4th Ave, Suite B, Post Falls, ID 83854 ("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 Member Amenities Fee (as defined below), Personalized Care Practice agrees to designate a physician 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 Member 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.

   The term "Effective Date" shall mean, for purposes of this Agreement and the Terms, the first (1st) or the sixteenth (16th) calendar day of the month, whichever occurs first following receipt by SignatureMD of a copy of this Agreement signed by the Program Member.

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, 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. **Membership Amenities Fee.** Program Member hereby selects the payment terms for the Program Services ("**Member Amenities Fee**") as indicated below and shall pay Member Amenities Fee in full in accordance with the terms. No part of the Member 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 MEMBER AMENITIES FEES	
(*Prepaid)	**(*Quarterly Installments)**
☐ Each Individual: $1,500.00 (annually)	☐ Each Individual: $1,500.00 (annually, $375.00 quarterly installments)

ADDITIONAL NOTES	

4. **Payment Authorization; Execution.** Program Member either (i) tenders together with this Agreement the Member Amenities Fee, or (ii) hereby authorizes Personalized Care Practice's designee to bill one/fourth (1/4) of the Member Amenities Fee (that is, $375.00) per calendar quarter, 3 months) payable in advance to Program Member's:

CREDIT/DEBIT CARD	☐ Visa	☐ MC	☐ Discover	☐ AMEX	CARD NO.	
CARDHOLDER'S NAME			EXPIRES		VERIFICATION #	

Program Member understands that credit card payments will be processed by Signature MD, Inc. and agrees to make payments by check payable to "***SignatureMD***" 4640 Admiralty Way, Suite 410, Marina del Rey, CA 90292

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)

(Print Name)

Riverview Personalized Care ,LLC

By: Lawrence K. Gibbon, MD

SCHEDULE 1 TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Additional Program Members (Riverview Personalized Care, LLC)

*Program Member from page 1.*_____

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: