Personalized Care Membership Agreement

SignatureMD
Human. Health. Care.

This **Personalized Care Membership Agreement** (this "Agreement") is made effective as of _____, (the "Effective Date") by and between the undersigned member and, if applicable, additional members listed on Schedule 1 hereto (each, a "Program Member"), and KENTUCKYONE HEALTH MEDICAL GROUP, INC, with the principal place of business at 200 Abraham Flexner Way, Louisville, KY 40202 ("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 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 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.

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.

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 accompanying this Agreement as Exhibit B (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. 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	☐ Each Individual: $2,000.00 (annually)	**Quarterly Installments** ☐ Each Individual: $2,200.00 (annually, $550.00 quarterly installments)
	☐ Two individuals (same household): total of $3,800.00 (annually)	☐ Two individuals (same household): $4,200.00 (annually, $1,050.00 quarterly installments)
	☐ Each additional individual (same household): $1,600.00 (annually)	☐ Each additional individual (same household): $1,800.00 (annually, $450.00 quarterly installments)

Additional Notes

*Member Amenities Fees shall increase by 3% on each annual renewal of this Membership Agreement.

5. 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, $_____) per calendar quarter (3 months) payable in advance to Program Member's:

Cardholder Name | Card Number | Expiration | Credit Card 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".

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 _____

KENTUCKYONE HEALTH MEDICAL GROUP, INC.

By Cathleen Morris, MD_____

Schedule 1 to Personalized Care Membership Agreement

Additional Members

SignatureMD
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Member Name from Member Agreement

Acknowledged and Agreed (Initials)

2nd Member

Member Name

Date of Birth

Email Address

Home Phone

Cell Phone

Office Phone

Fax

Mailing Address

City

State

Zip Code

3rd Member

Member Name

Date of Birth

Email Address

Home Phone

Cell Phone

Office Phone

Fax

Mailing Address

City

State

Zip Code

4th Member

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 KENTUCKYONE HEALTH MEDICAL GROUP, INC. (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 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 personalized care program 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 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 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
Cathleen Morris, MD	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)