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 Terri Esterowitz MD, an individual, having an address of 1201 Seven Locks Road Suite 111, Rockville MD, 20854 ("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 as published on Signature MD, Inc.'s website (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 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 Annual	Individual $1,800.00
	2+ Individuals $1,620.00
	Each Additional $1,620.00
	Child $500.00

Quarterly Installments	Individual $1,800.00 ($450.00 Quarterly)
	2+ Individuals $1,620.00 ($405.00 Quarterly)
	Each Additional $1,620.00 ($405.00 Quarterly)
	Child $500.00 ($125.00 Quarterly)

Payment Frequency	☐ Annual
	☐ Quarterly

Notes	

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 the Member Amenities Fee (that is, $_____) payable in advance to Program Member's (please complete one):

Credit or Debit Card

Cardholder Name	Card Number	Expiration	CVV	Card Zip Code

eCheck (ACH)

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

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 _____

Terri Esterowitz MD

By Terri Esterowitz MD _____

Schedule 1 to Personalized Care Membership Agreement

Additional Members

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 information pertaining to me that is maintained by Terri Esterowitz MD (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 Signature MD, Inc., the 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
Terri Esterowitz 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)

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
Terri Esterowitz 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