Personalized Care Program Agreement

SignatureMD
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This **Personalized Care Program Agreement** (this "Agreement") is made effective as of ______________________, (the "Effective Date") by and between the undersigned patient and, if applicable, additional patients listed in Schedule 1 to this Agreement (each, a "Participating Patient"), and SUE SANCHEZ, MD, an individual, having an address of 1661 Lucerne St, Minden, NV 89423 ("Personalized Care Practice"; and together with (Participating Patient(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 Participating Patient 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. Participating Patient Information; Additional Participating Patients. Participating Patient 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 Participating Patients, 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.

Participating Patient Name	Date of Birth	Email Address	
Home Phone	Cell Phone	Office Phone	Fax
Mailing Address	City	State	Zip Code

3. HIPAA Release/Consent. Participating Patient 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, Participating Patient will sign and deliver the Authorization to Personalized Care Practice.

4. Amenities Fee. Participating Patient 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 Participating Patient hereunder is being paid in consideration for any medical services covered by Participating Patient's insurer, health plan or by any governmental program, including Medicare.

Annual Amenities Fees

Prepaid Annual	
	Individual $2,060.00 (Prepaid)
	Additional $1,854.00 Individual (Prepaid)**

Quarterly Installments	
	Individual $2,120.00/$530.00 (Quarterly)
	Additional $1,908.00/$477.00 Individual (Quarterly)**

Payment Frequency	
	☐ Annual
	☐ Quarterly

*Amenities Fees shall increase by 3% on each annual renewal of this Personalized Care Program Agreement.

**Additional participating patient discounts will be allocated equally amongst all participants.

Notes	

5. Payment Authorization; Execution. Participating Patient 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 Participating Patient(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 ☐ Savings

Participating Patient 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.

Participating Patient

Signature ____

Print Name ____

SUE SANCHEZ, MD

By Sue Sanchez, MD ______________________________________

Schedule 1 to Personalized Care Program Agreement

Additional Participating Patients

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Participating Patient Name from Personalized Care Program Agreement

Acknowledged and Agreed (Initials)

2nd Participating Patient

Participating Patient Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

3rd Participating Patient

Participating Patient Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

4th Participating Patient

Participating Patient 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 SUE SANCHEZ, 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 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 Participating Patient Printed Name	Signature of Patient or Representative	Date
2nd Participating Patient Printed Name	Signature of Patient or Representative	Date
3rd Participating Patient Printed Name	Signature of Patient or Representative	Date
4th Participating Patient Printed Name	Signature of Patient or Representative	Date
SUE SANCHEZ, MD	Date	

If by and through a representative of a Participating Patient

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

(Describe relationship to Participating Patient, or source of authority to sign on Participating 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 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 Participating Patient Printed Name	Signature of Patient or Representative	Date
2nd Participating Patient Printed Name	Signature of Patient or Representative	Date
3rd Participating Patient Printed Name	Signature of Patient or Representative	Date
4th Participating Patient Printed Name	Signature of Patient or Representative	Date
SUE SANCHEZ, MD	Date	

If by and through a representative of a Participating Patient

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

(Describe relationship to Participating Patient, or source of authority to sign on Participating Patient's behalf)