Welcome to the SignatureMD Family

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

Fax
888.536.0526

Complete a hard copy of the agreement, sign it, and fax it to SignatureMD at 888.536.0526

Email
thusbands@signaturemd.com

Complete a hard copy of the agreement, sign it, scan it, and email it to SignatureMD Patient Liaison, Taylor Husbands at thusbands@signaturemd.com

Mail
SignatureMD

Complete a hard copy of the agreement, sign it, and mail it to SignatureMD at:

SignatureMD
4640 Admiralty Way
Suite 410
Marina Del Rey, CA 90292

If you are paying by check, please make checks payable to SignatureMD

Personalized Care Membership Agreement

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 SAGAR VERMA, MD, an individual, having an address of 147 Alexandria Pike, Suite 104, Warrenton, VA 20186 ("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 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		Quarterly Installments		Additional Notes
☐	Individual $1,800.00 (Prepaid)	☐	Individual $2,000.00/$500.00 (Quarterly)	
☐	Additional $1,700.00 Individual (Prepaid)	☐	Additional $1,900.00/$475.00 Individual (Quarterly)	

*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 ____

Sagar Verma, MD

By Sagar Verma, 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 SAGAR VERMA, MD (the "Entity").

1. This Authorization concerns the following 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
Sagar Verma, 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)

SignatureMD
Human. Health. Care.

TERMS AND CONDITIONS OF SERVICE TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Version Dated as of September 26, 2019

1. BACKGROUND
Sagar Verma, MD ('**Personalized Care Practice**") operates a personalized care medicine program known as SignatureMD Personalized Care Program ("**Personalized Care Program**") providing certain professional non-clinical services, enhancements and amenities associated with healthcare services to the Program Members and other persons who have subscribed to and enrolled in the Personalized Care Program, and in connection therewith has entered into that certain Personalized Care Program Physician Participation Agreement ("**SignatureMD Agreement**"), with Signature MD, Inc., a company that facilitates certain non-medical aspects of the Personalized Care Practice.

Program Members desire to subscribe to and enroll in the Personalized Care Program on the terms and conditions set forth below in this Terms and Conditions of Service and the accompanying Personalized Care Membership Agreement (the "**Membership Agreement**"). These Terms and Conditions of Service (these "**Terms**") accompany and supplement the Membership Agreement and constitute the Terms referenced therein (these Terms, the Membership Agreement and all Schedules and Exhibits, collectively, the "**Agreement**"). Any capitalized term used but not defined herein shall have the meaning given to it in the Membership Agreement.

In order to induce each other to enter into the Agreement, in consideration of the mutual promises and undertakings set forth in the Membership Agreement and these Terms 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:

2. PROGRAM SERVICES
a) Personalized Care Practice agrees to provide to you certain enhancements and amenities to the professional medical services to be rendered by Personalized Care Practice to you, as further described in Schedule 1 to these Terms. Upon prior written notice to you, Personalized Care Practice may add or modify the Program Services set forth in Schedule 1 and subject to such additional fees and/or terms and conditions.
b) I acknowledge that the Program Services are services that are not covered services under any insurance contract to which I am or may be a party, including, without limitation, Medicare, and are not reimbursable by my insurer, health plan or any governmental entity, including Medicare. I agree to bear sole financial responsibility for the Member Amenities Fee and agree not to submit to my insurer, health plan or governmental entity any bill, invoice or claim for payment or reimbursement of such Member Amenities Fee.
c) I understand that Personalized Care Practice or its designated affiliate will separately charge me or my insurer, health plan or governmental entity for medical, clinical, diagnostic or therapeutic services rendered by Personalized Care Practice or its designated affiliate to me, and I may seek payment or reimbursement from my insurer or health plan for any such service to the extent covered by my insurer, health plan or governmental entity.
d) I understand, agree and covenant that this Agreement is a service contract, and not a contract for insurance.

3. DESIGNATED PHYSICIAN. Personalized Care Practice designates Sagar Verma, MD, as "**Designated Physician**" to render medical services to Program Member(s) in accordance with the Membership Agreement and these Terms. I understand and acknowledge that Physician may not be available from time to time and may designate, on a temporary basis during Physician's unavailability, a covering physician or other licensed medical professional who will be allowed access to my medical history and course of care to attend to my medical care needs. The term "Personalized Care Practice," as used throughout these Terms and in the Membership Agreement, covers the Personalized Care Practice, licensed individual designated as the Designated Physician herein and such other practitioner as may be designated parties in the Designated Physician's absence.

4. TERM. Unless earlier terminated as set forth in Section 7 (below), the initial term of the Agreement shall be for one year, commencing on the effective date of the Membership Agreement (the "**Effective Date**") and terminating on the day following the first anniversary of the Effective Date (the "**Initial Year**"). Thereafter, the Agreement shall automatically renew for successive one-year periods (each, a "**Renewal Year**"), unless either party notifies the other party in writing, not less than 30 days prior to the expiration of the Initial Year or the Renewal Year, as applicable, of such party's decision not to renew the Agreement. However, I understand that the Agreement will not automatically renew if I am not current in all my financial obligations to Personalized Care Practice.

5. MEMBERSHIP FEE. I agree to and shall pay the Member Amenities Fee as provided in the Membership Agreement. Unless this Agreement is not renewed, as provided in Section 4 (above), subsequently, I understand I will be billed for the Member Amenities Fee for each Renewal Year prior to the beginning of each Renewal Year, and I agree to pay the invoiced Member Amenities Fee within 30 days after the date of the invoice. In order to facilitate the administration of the Personalized Care Practice and the Program Services, Personalized Care Practice hereby appoints Signature MD, Inc. to perform all billing and collections functions associated with the Member Amenities Fee (but not for medical services covered under any insurance contract, including Medicare). Accordingly, you agree to submit all payments of Member Amenities Fees to Signature MD, Inc., as follows:

Signature MD, Inc., 4640 Admiralty Way, Suite 410 Marina del Rey, CA 90292 / (866) 883-8859 / www.signatureMD.com

Any checks for payment of the Member Amenities Fees shall be made payable to, and any credit card payments shall be processed by, Signature MD, Inc.

6. ELECTRONIC COMMUNICATION
a) Unless advised otherwise in writing, I authorize the Personalized Care Practice and its staff and designees to communicate with me by Electronic Communication regarding my personal health information (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations; "PHI") at my e-mail address shown on the signature page of this Agreement. Electronic Communication includes but is not limited to cell phone, email, text, and video conference.
b) I acknowledge and agree that:
  i. Electronic Communication may not be a secure medium for sending or receiving PHI;
  ii. Although the Personalized Care Practice and its staff and designees will make reasonable efforts to keep Electronic Communication among me, the Personalized Care Practice and Practice's designee(s) (and their employees, agents and representatives) confidential and secure, I understand that they cannot assure or guaranty the confidentiality of Electronic Communication;
  iii. In the discretion of Personalized Care Practice, Electronic Communication may be made a part of my permanent medical record; and
  iv. Electronic Communication is not an appropriate primary means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of a true medical emergency, please dial 911 or head to your nearest emergency room.
c) I further acknowledges and agrees that:
  i. I will call 911 or proceed to my nearest emergency room in the event of a medical emergency and I will not use Electronic Communication as a primary means of communicating regarding emergencies or other time-sensitive issues, or for communication regarding sensitive information;
  ii. If I do not receive a response to my Electronic Communication message within one (1) business day (or such longer time as I have indicated in the Electronic Communication), I will use another means of communication to contact Personalized Care Practice or appropriate representative;
  iii. When using Electronic Communications, I will include my full name and a short description of the subject matter of the Electronic Communication (e.g., "medical advice", "billing question") in the "Re" or "Subject" line of the Electronic Communication;
  iv. When responding to an Electronic Communication from Personalized Care Practice or its staff or representative, I will use "Reply with History" to ensure that the recipient is aware of the previous communication; and
  v. Neither Personalized Care Practice nor any of its agents, consultants or representatives will be liable to me or my heirs for any loss, damage, cost, injury or expense caused by, or resulting from: (i) a delay in response to my Electronic Communications due to technical failures, including, but not limited to, technical failures attributable to internet service provider, power outages, failure of electronic messaging software, failure by Practice, or any of its agents, consultants or representatives to properly address Electronic Communication messages, failure of computers or computer network, or faulty telephone or cable data transmission; (ii) any interception of Electronic Communication by a third party; or (iii) my failure to comply with the guidelines regarding use of Electronic Communication set forth in this Section 6.

7. TERMINATION

a) You may terminate this Agreement at any time upon thirty days prior written notice to Personalized Care Practice and Signature MD. You will not be entitled to a refund of Member Amenities Fee or a portion thereof, except as provided in Section 7(b) below.

b) Personalized Care Practice may terminate this Agreement, at any time, upon (i) occurrence of your breach of this Agreement if such breach is not cured within 10 days; or (ii) 30 days prior written notice to you, with or without cause, related to the patient-physician relationship or any other non-contract related issue; provided, however, that you will be entitled to a refund of a prorated portion of the Member Amenities Fee paid by you for the year in which termination becomes effective.

c) Notwithstanding anything to the contrary, Personalized Care Practice or its designee may terminate this Agreement with respect to any Program Member at any time **prior** to the Effective Date for any reason or no reason by giving notice of termination to such Program Member. Any Program Member terminated under this provision will be entitled to receive full refund of Member Amenities Fees or a portion thereof and Personalized Care Practice or its designee will provide refund to the terminated Program Member within fourteen (14) days after the termination.

8. NOTICES. Any communication required or permitted to be sent under this Agreement (other than communications referenced in Section 6 relating to my PHI) will be in writing and sent via facsimile, recognized overnight courier or certified mail, return receipt requested, to the addresses set forth on the signature page. Any change in address will be communicated to the Parties and SignatureMD in accordance with the provisions of this Section 8.

9. INDEPENDENT MEDICAL JUDGMENT. Notwithstanding anything to the contrary contained in this Agreement or in the SignatureMD Agreement, Personalized Care Practice retains full and free discretion to, and shall, exercise his/her professional medical judgment on behalf of you with respect to medical services rendered to you, and nothing in this Agreement shall be deemed or construed to influence, limit or affect a physician's independent medical judgment with respect to Personalized Care Practice's provision of medical services to you and your medical treatment.

10. CHANGE OF LAW. If there is a change in any state or federal law, regulation or rule or interpretation thereof, which affects this Agreement or the activities of either party under this Agreement, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within thirty (30) days after the date of the notice seeking renegotiation, then either party may terminate this Agreement by written notice to the other party.

11. GOVERNING LAW; ARBITRATION. This Agreement shall be governed and interpreted in accordance with, and the rights of the parties shall be determined by, the laws of the State of Virginia, without regard to conflicts of laws principles. THE PARTIES INTENTIONALLY AND VOLUNTARILY WAIVE ANY RIGHT TO A TRIAL BY JURY IN ANY MATTER ARISING OUT OF THIS AGREEMENT.

ANY DISPUTE BETWEEN YOU AND PERSONALIZED CARE PRACTICE OR YOURS/ITS RESPECTIVE AFFILIATES AND AGENTS ARISING UNDER OR RELATING TO THIS AGREEMENT SHALL BE RESOLVED EXCLUSIVELY BY ARBITRATION IN THE STATE OF VIRGINIA, BEFORE AN ARBITRATOR AGREED TO BY BOTH PARTIES WITHIN 30 DAYS OF THE REQUEST FOR ARBITRATION AND BARRING AGREEMENT THE PARTIES AGREE THAT JAMS SHALL CHOOSE THE ARBITRATOR, under the auspices of the Comprehensive Arbitration Rules & Procedures of JAMS Mediation, Arbitration and ADR Services, in accordance with its then current Expedited Rules and Procedures for Commercial Arbitration. Any award rendered pursuant to such arbitration shall be final and binding upon the parties, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction over parties. Each party shall bear its own costs and attorneys' fees in connection with any such arbitration.

12. NO LIABILITY. Except as required by applicable law, neither Personalized Care Practice nor any of its agents, consultants or representatives shall be liable to you for any damages or liability arising out of or related to the Agreement. In any event, each parties' liability under the Agreement, shall be limited to amount that is equal to the aggregate Member Amenities Fees paid by you during the twelve-month period preceding the date on which the claim arises. In no event will any party be liable for any indirect, consequential, special or punitive damages of any kind, whether arising in contract, tort, strict liability or otherwise, to the full extent permitted by the applicable law arising out of or related to the Agreement.

13. WAIVER. The failure of a party to insist upon strict adherence to or performance of any term of the Agreement on any occasion will not be considered a waiver of the right to require adherence on any other occasion or regarding any other matter.

14. SEVERABILITY. If any provision of the Agreement is declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of the Agreement will remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein.

15. ASSIGNMENT. You may not assign the Agreement. Personalized Care Practice shall have the right to assign this Agreement to a wholly owned entity formed to administer the Personalized Care Program in accordance with the terms and conditions set forth in the Agreement.

16. ENTIRE AGREEMENT; AMENDMENT. The Agreement contains the entire agreement of the parties and supersedes all prior agreements and understandings between the parties regarding the subject matter hereof. The Agreement may only be amended by a written agreement of both parties, except that Personalized Care Practice may amend any provision of the Agreement, including these Terms, other than the term and the amount of Member Amenities Fee, by giving written notice to you at least fifteen days in advance of any such change or amendment taking effect.

SCHEDULE 1 to SignatureMD Terms and Conditions of Service - Personalized Care Program Services: Enhancements & Amenities [1]

1. **Program Limits**. Personalized Care Practice agrees to limit the number of personalized care members to enroll into the Personalized Care Practice to the number agreed upon between the Personalized Care Practice and SignatureMD.
2. **Enhanced Appointment Scheduling Options**. Same-day and next-day appointments that are medically necessary in the Designated Physicians professional judgment are covered by your health plan, and are not part of this Membership Agreement and payment of Member Amenities Fee is not a condition to receipt of such medical services. When not medically necessary, you are entitled to enhanced options for scheduling of appointments for any medical care. When you make an appointment that does not require urgent medical attention, you will nevertheless be seen promptly by the Designated Physician as if you had an urgent medical condition.
3. **Communication Enhancements.** You will be provided with a cellular or another personal phone number, facsimile or email address for contacting Designated Physician or designee and detailed instructions on how to contact Designated Physician for non-emergency questions or requests through these means (collectively, the "Communications Enhancements.")
4. **Prompt Communication.** If you desire to communicate with Designated Physician on a non-urgent issue or with non-urgent questions then Designated Physician will communicate promptly with you. Communications for urgent matters should be made by phone call to the office telephone number. Communication for non-urgent matters between the doctor or her designee and you will be made within a business day and a plan will be made between the parties for any further follow-up as necessary.
5. **Enhanced Appointments**. When medically necessary, extended patient appointments shall be provided in Designated Physician's professional judgment, not as a Program Service. When not medically necessary, following each appointment with Designated Physician, additional time will be made available so that you can ask additional questions relating to Program Enhancements and Amenities, alternative or investigative treatment options, vitamins, dietary supplements, nutraceuticals and other items not specific to treatment of a specific medical condition.
6. **Personal Administrative Assistant**. A representative of Personalized Care Practice will be dedicated to you to assist addressing and coordinating the administrative aspects of the Personalized Care Practice and Program Services.
7. **Comprehensive Health Planning**. Arrangements will be made for Personalized Care Practice to provide a maximum of three periodic in person health planning assessments to you in addition to the annual physical examination that is generally covered by health plans, to set your health goals and to evaluate progress in achieving those goals. The parameters of the periodic health assessments will include only items that are not covered by your health insurance, health plan or any benefits offered by a governmental entity, including Medicare. Arrangements will also be made for the Designated Physician to be available to coach you to address environmental and other obstacles to health improvement and wellbeing that are not specific to the treatment of a specific medical condition.
8. **Personalized Health Education.** Arrangements will be made to provide you with regular personalized health information on topics pertinent to your health, including bulletins, health articles and website postings that may cover vitamin supplements and holistic treatment options and health care supplements. Any such information will be conveyed via private web posting, portal or individual e-mail. Arrangements may also be made to arrange for you to attend education, lecture, support group and discussion sessions, at your choice. (Additional registration fees may apply for such sessions.)

[1] Member Amenities Fees are solely for the Enhancements and Amenities listed in this Schedule that are furnished, or arranged to be furnished. Physician will seek reimbursement from your health plan only for covered medical services.