SignatureMD
Human. Health. Care.

We're taking a proactive approach to your care

Vera L. Sheen, MD

We believe that the goal of healthcare should be to prevent health issues, rather than simply treat them. That's why we're offering a new personalized approach to help you optimize your health.

Instead of adhering to the standard healthcare model, which focuses on managing illness, we're breaking the mold to provide personalized attention and improved care options, designed to help you reach and maintain your health goals.

With this new program, you'll experience benefits such as:

- A wellness plan customized to your personal health goals
- Unhurried appointments that begin on time
- Appointments the same or next business day
- Dr. Sheen's undivided attention
- 24/7/365 physician availability via phone or email
- Office visits for visiting friends and family

Your SignatureMD healthcare partner

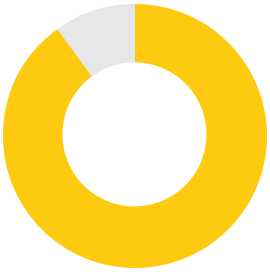
Dr. Sheen has had over 25 years of experience as primary care physician. She grew up in Kentucky and attended the University of Kentucky School of Medicine, where her interest in primary care began. She went to Washington University in St. Louis for her Internship and Residency training in Internal Medicine and from there, she came to the metro DC area where she met her husband. His work subsequently took them overseas for 10 years where she lived and practiced medicine in several beautiful countries (Philippines, Vietnam, Italy, and UAE), learning and appreciating the different cultures and health standards. Dr. Sheen joined Primary Care at Foxhall in 2011. Her philosophy is to treat her patients as a whole and to involve them and help them better understand their health needs.

The remedy for a broken healthcare system

Under the current U.S. healthcare model, the typical medical practice must maintain a roster of thousands of patients just to remain sustainable. This means that patients typically have to wait more than 20 minutes for a mere 13-minute visit with their doctor. Even worse, once they see the doctor, their care options are limited to what's allowed by their insurance provider as medically necessary.

To remedy this problem, I've chosen to personally manage the care of a few hundred program members. By carefully managing my time, I can offer you my undivided attention for a full 30 to 45 minutes per visit. This additional time enables me to get to know you, better understand your health condition, and determine what's best for you—rather than what's best for your insurance company.

It's a bit like having a trusted friend who happens to be a physician. You can take your time, ask all the questions you'd like, and get thoughtful answers from someone who fully listens to you and understands your concerns.



90% of concierge patients are satisfied with their care according to the AARP

How the Personalized Care Program works

Implementing your Personalized Care Program is the first step toward reaching your health goals. We'll work together to detect early signs of illness and, through increased interaction, education, and follow-up, strive to keep you healthy and vibrant.

We'll spend the time to discuss the results of your examination and tests, identify areas for improvement, and craft a personalized plan based on our agreed-upon objectives. Once your plan has been established, we'll work closely with you to monitor your progress and ensure that you stay on track.

Ultimately, good health costs less than poor health

Under this new program, you'll benefit from some of the finest service and most attentive care in the nation. Our goal is to help you optimize your well-being and spend less money over the long term on expenses like prescription drugs, hospitalization, specialist visits, and other costs associated with managing disease.

To cover the additional services and attention you'll receive from the doctor, you'll be asked to pay an affordable membership fee for services that aren't covered by your insurance plan; however, we'll also continue to bill your insurance company for processing of your covered medical benefits.

Let us show you how to take the first step toward better health now.

Learn how our personalized healthcare approach may help detect early signs of serious illness and improve your overall well-being. Visit us online or call our office for additional details.

SignatureMD
Human. Health. Care.

Vera L. Sheen, MD
5215 Loughboro Road NW
Suite 530
Washington, DC 20016
202.895.0050
SignatureMD.com/sheen

SignatureMD
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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
202.895.0051

Complete a hard copy of the agreement, sign it, and fax it to the doctor's office at 202.895.0051

Email
estewart@signaturemd.com

Complete a hard copy of the agreement, sign it, scan it, and email it to SignatureMD patient liaison, Elise Stewart at estewart@signaturemd.com

Mail
Vera L. Sheen, MD

Complete a hard copy of the agreement, sign it, and mail it to the doctor's office at:

Vera L. Sheen, MD
5215 Loughboro Road NW | Suite 530
Washington, DC 20016

If you're paying by check, please make checks payable to SignatureMD.

Personalized Care Program Agreement

SignatureMD
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This **Personalized Care Program Agreement** (this "Agreement") is made effective as of September 16, 2023, (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 VERA L. SHEEN, MD , an individual, having an address of 5215 Loughboro Road NW, Suite 530, Washington, DC 20016 ("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	☐	1 Participant $1,900.00		**Quarterly Installments**	☐	1 Participant $2,100.00 ($525.00 Quarterly)	
	☐	2 Participants $1,700.00 each	$3,400.00 total per Family**		☐	2 Participants $1,900.00 each ($475.00 Quarterly)	$3,800.00 total per Family ($950.00 Quarterly)**
	☐	3 Participants $1,633.33 each	$4,900.00 total per Family**		☐	3 Participants $1,833.33 each ($458.33 Quarterly)	$5,500.00 total per Family ($1,375.00 Quarterly)**
	☐	4 Participants $1,600.00 each	$6,400.00 total per Family**		☐	4 Participants $1,800.00 each ($450.00 Quarterly)	$7,200.00 total per Family ($1,800.00 Quarterly)**
	☐	5 Participants $1,580.00 each	$7,900.00 total per Family**		☐	5 Participants $1,780.00 each ($445.00 Quarterly)	$8,900.00 total per Family ($2,225.00 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 Participating Patient 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

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 _____

VERA L. SHEEN, MD

By Vera L. Sheen, MD _____

Schedule 1 to Personalized Care Program Agreement

Additional Participating Patients

SignatureMD
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Participating Patient Name from Personalized Care Program Agreement

Acknowledged and Agreed (Initials)

2nd Participating Patient

☐ Scholarship ☐ Dependent

Participating Patient Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

3rd Participating Patient

☐ Scholarship ☐ Dependent

Participating Patient Name | Date of Birth | Email Address

Home Phone | Cell Phone | Office Phone | Fax

Mailing Address | City | State | Zip Code

4th Participating Patient

☐ Scholarship ☐ Dependent

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 VERA L. SHEEN, 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
VERA L. SHEEN, 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, 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
VERA L. SHEEN, 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)

Terms and Conditions of Service
To Personalized Care Program Agreement

Version Dated as of April 1, 2022

1. Background.
VERA L. SHEEN, MD ("**Personalized Care Practice**") operates a private direct personalized care medicine program known as SignatureMD Personalized Care Program ("**Personalized Care Program**") providing Program Services (as defined below) to the Participating Patients ("you", "your", "I", "my") 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.

Participating Patient desires 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 Program Agreement (the "**Personalized Care Program Agreement**"). These Terms and Conditions of Service (these "**Terms**") accompany and supplement the Personalized Care Program Agreement and constitute the Terms referenced therein (these Terms, the Personalized Care Program Agreement and all Schedules and Exhibits, all collectively, the "**Agreement**"). Any capitalized term used but not defined herein shall have the meaning given to it in the Personalized Care Program Agreement.

In order to induce each other to enter into the Agreement, in consideration of the mutual promises and undertakings set forth in the Personalized Care Program 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 specific services outside of any private or public healthcare insurance plan coverage, supported by 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 to these Terms 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 public or private healthcare 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 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 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 Vera L. Sheen, MD, as "**Designated Physician**" to render medical services to Participating Patient(s) in accordance with the Agreement and these Terms. I understand and acknowledge that Designated Physician may not be available from time to time and may designate, on a temporary basis during Designated 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 Agreement, covers the Personalized Care Practice, the licensed individual designated as the Designated Physician herein, and any 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 (1) year, commencing on the effective date of the 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. Amenities Fee. I agree to and shall pay the Amenities Fee as provided in the Agreement. Unless this Agreement is not renewed, as provided in Section 4 (above), subsequently, I understand I will be billed for the Amenities Fee for each Renewal Year prior to the beginning of each Renewal Year, and I agree to pay the invoiced 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 Amenities Fee (but not for medical services covered under any insurance plan contract, including Medicare). Accordingly, you agree to submit all payments of Amenities Fees to Signature MD, Inc., as follows:

Signature MD, Inc., 6001 Broken Sound Parkway NW, Suite 340, Boca Raton, FL 33487/ (866) 883-8859 / www.signatureMD.com

Any checks for payment of the 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 guarantee 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 acknowledge and agree 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 (30) days prior written notice to Personalized Care Practice and Signature MD. You will not be entitled to a refund of the 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 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 Participating Patient at any time **prior** to the Effective Date for any reason or no reason by giving notice of termination to such Participating Patient. Any Participating Patient terminated under this provision will be entitled to receive full refund of Amenities Fees or a portion thereof and Personalized Care Practice or its designee will provide refund to the terminated Participating Patient 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 District of Columbia, 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 DISTRICT OF COLUMBIA, 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 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 the 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[1]

1. **Program Limits**. Personalized Care Practice agrees to limit the number of personalized care Participating Patients to enroll into the Personalized Care Practice to the number agreed upon between the Personalized Care Practice and SignatureMD.

2. **Routine Regardless Of Medical Condition Or Necessity Physical Checkups/Exams.** Participating Patients shall have available to them no less than one (1) annual routine diagnostic physical checkup or exam (the "routine exam") that is broad-based, more comprehensive than plan-covered exam services, and detached from medical condition or medical necessity and supported by follow-up routine exams (virtual or in-office) designed to help the Participating Patient achieve health goals and to help detect or avoid disease when possible. This routine exam may include, subject to change, BMI, body composition, weight, blood pressure, nutritional intake, exercise assessment, stress management, sleep patterns using simple questionnaires (e.g. PSQI, ISI), review of medications, mental health, lifestyle in-take. Such routine exams will be supported by a medical information plan that shall facilitate Participating Patient/healthcare routine exam-related professional communications and store routine exam-related health data. This routine exam will be in addition to and well beyond the features of any private or public plan preventative physical or annual wellness visit that lacks the more broad-based features and related communication support provided by private fee routine exam services. Due to this high-connection style of ongoing routine exam care, along with a limited patient panel, Participating Patients will enjoy (not as a private fee Program Service, but incidental to the program features and small patient panel size) same-day and next-day appointments and scheduling conveniences.

3. **Medical Information Plan Communication Features.** 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 Routine Exam-Supporting Communications.** If you desire to communicate with Designated Physician on routine exam health goals and concerns, then a 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. **Routine Exam Appointment Conveniences.** Routine exam appointments will be facilitated and efficiently managed in connection with the enhanced features of the medical information plan supporting routine exam services.

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. **Wellness Improvement Plan**. Personalized Care Practice will create a Wellness Improvement Plan based on routine exam services addressing routine exam-based Participating Patient health goals related to weight loss, stress reduction, increased physical activity, reduction or elimination of medications.

8. **Health Planning.** Arrangements will be made for Personalized Care Practice to provide a maximum of three (3) periodic counseling sessions via phone, in person or video to review Participating Patient's adherence to and results of the Wellness Improvement Plan. 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. The counseling sessions are in addition to the annual physical examination that is generally covered by health plans. The parameters of the annual 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.

9. **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. You will be responsible for payment of any such additional fees, and you may arrange to have any additional fees paid by a third party.)

[1] 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.