PERSONALIZED CARE MEMBERSHIP AGREEMENT

THIS PERSONALIZED CARE MEMBERSHIP AGREEMENT (this **"Agreement")** is made effective as of the Effective Date (as defined below in Section 1), by and between the **undersigned member** and, if applicable, **additional members** listed on Schedule 1 hereto (each, a **"Program Member"),** and 65 CPW Medical, PC, a limited liability company, with the principal place of business at 65 Central Park West, Suite IG, New York, NY 10023 **("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 physician 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. The term "Effective Date" shall mean, for purposes of this Agreement and the Terms, the first (1st) or the sixteenth (16th) calendar day of month, whichever occurs first following receipt by Signature MD of a copy of this Agreement signed by the Program Member.

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.

A1. PREFIX	A2. MEMBER NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

3. **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		
Each Individual:	**Number of Members** ☐	**Total=** $

ADDITIONAL NOTES	

4. **Payment Authorization; Execution.** Program Member tenders together with this Agreement the Member Amenities Fee and authorizes Personalized Care Practice's designee to bill the Member Amenities Fee per calendar year payable in advance to Program Member's:

CREDIT/DEBIT CARD		Visa		MC		Discover		AMEX	NAME	
CARD NUMBER						EXPIRATION		CVV		ZIPCODE

Program Member understands and agrees to send checks for applicable Member Amenities Fees to:
65 CPW Medical, PC, c/o Signature MD, 6001 Broken Sound Pkwy NW, Suite 340, Boca Raton, FL 33487

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)

Personalized Care Practice

By:

Name:
Title:

Date:

SCHEDULE 1 TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Additional Program Members {65 CPW Medical, PC)

A1. PREFIX	A2. 2ND MEMBER'S NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

D1. HOME PHONE	D2. MOBILE PHONE	D3. OFFICE PHONE	D4. FAX

E1. MAILING ADDRESS	E2. CITY	E3. STATE	E4. ZIP-CODE

F. UNDER 26 YEARS OLD	G. ACKNOWLEDGED AND AGREED
y N	INITIALS:

A1. PREFIX	A2. 2ND MEMBER'S NAME	B. DATE OF BIRTH	C. E-MAIL ADDRESS

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