PERSONALIZED CARE MEMBERSHIP AGREEMENT

signature MD®

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 JJWBAB Corp., a California corporation. ("**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.
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.

A. 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. **HIPAA Release/Consent.** Program Member agrees, consents and authorizes Personalized Care Practice to disclose all of his/her protected medical 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)	
	Each individual $2000 (annually)		Individual $2200 annual ($550 per quarter)
	Two (2) adult individuals $3700 (annually)		Two (2) adult individuals $4100 ($1025 per quarter)
	Third (3rd) additional adult individual $1500 (annually)		Third (3rd) additional adult individual $1600 ($400 per quarter)

ADDITIONAL 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 one-fourth (1/4) of the Member Amenities Fee (that is, $____________) per calendar quarter (3 months) payable in advance to Program Member's:

CREDIT/DEBIT CARD		Visa		MC		Discover		AMEX	CARD NO.			
CARDHOLDER'S NAME						EXPIRES				VERIFICATION #		

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) By: Joseph J. Walters, M.D.

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SCHEDULE 1 TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Additional Program Members

A. 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. ACKNOWLEDGED AND AGREED
INITIALS:

A. 3RD 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. ACKNOWLEDGED AND AGREED
INITIALS:

A. 4TH 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. ACKNOWLEDGED AND AGREED
INITIALS: