PERSONALIZED PRIMARY CARE

MEMBERSHIP AGREEMENT- ***Celebration***

This Membership Agreement (the "Agreement") specifies the terms and conditions under which you, the undersigned member ("Member"), will be enrolled with PERSONALIZED PRIMARY CARE program (the "Program"). This Agreement will become effective as of the date set forth by James G. Scelfo, MD, PA // DBA: PERSONALIZED PRIMARY CARE, located **602 Front Street Celebration Florida, 34747**, at the end of this Agreement (the "Effective Date").

1. **PERSONALIZED PRIMARY CARE Benefits and Services.** The Program provides the following amenities ("Amenities") to persons who sign up as Members:

- Individual Healthcare with a Focus on Prevention
- 24/7 Direct Access to Physician
- Limited Patient Membership
- Individual, Couple and Family Plans
- Same Day / Next Day - urgent/emergency Appointments
- Fitness Counseling
- Your Choice of a 1 Hour consultation with a Nutritionist, Physical Therapist or Family Counselor
- Referral Coordination and Scheduling
- Preventative Care Focus
- 90 minute Initial Comprehensive Consultation and Physical
- 1 hour Annual Physical Examination
- 30 minutes of personal care for each appointment
- Designated Parking Area
- Upscale Office Design
- Private Reception
- Phone/Fax/Web Access
- Electronic Medical Records
- Secure Internet Patient Portal
- In office blood draw for lab work

The Amenities include both non-healthcare service amenities and health-related services usually not covered by insurance. Other service amenities may be offered from time to time, and these may be subject to limitations.

Membership Fee. *Please check the appropriate box for your desired membership status:*

2. Members will pay a membership fee to PERSONALIZED PRIMARY CARE. For each child membership an individual adult membership must be maintained. You must provide a valid credit card on file with PPC to select the monthly or quarterly membership status options.

☐ ***Monthly*** (includes a 5% administrative fee)

Monthly memberships will process on the first day of every month to the credit card provided below

☐ $157.50 Individual Membership ☐ $271.25 Couple Membership ☐ $43.75 Child up to age 18

☐ $131.25 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Quarterly***

Quarterly memberships will process on the first day of each quarter to the credit card provided below

☐ $450.00 Individual Membership ☐ $775.00 Couple Membership ☐ $125.00 Child up to age 18

☐ $375.00 per Additional Family Member (up to 2 additional family members with couple membership)

☐ ***Annually***

Annual memberships will bill to you on a yearly basis according to your anniversary date/effective date.

☐ $1800 Individual Membership ☐ $3100 Couple Membership ☐ $500 Child up to age 18

☐ $1500 per Additional Family Member (up to 2 additional family members with couple membership)

MEMBER BILLING -- INCLUDE YOUR PAYMENT ALONG WITH THE SIGNED MEMBERSHIP AGREEMENT.

☐ VISA ☐ MasterCard ☐ American Express ☐ Check ☐ Cash

Name on Card_____

Billing Address _____City/State _____ Zip Code _____

Card Number_____

Expiration Date_____Verification Code _____

Signature of Cardholder_____

Check # _____

3. **Renewals and Termination.** The annual membership fee covers a period of one (1) year. Failure to pay the renewal annual membership fee within 30 days from the anniversary of the Effective Date shall result in termination of your membership in the Program. (For example, if the Effective Date is May 15, 2002 then you must renew on or before June 14, 2003). You may terminate your

participation at any time upon 30 days prior written notice to PERSONALIZED PRIMARY CARE. **If you terminate this Agreement for any reason, you will be entitled to a refund of any unused portion of your annual membership fee.** PERSONALIZED PRIMARY CARE may terminate this Agreement at any time on 30 days written notice to you. If PERSONALIZED PRIMARY CARE terminates this Agreement for any reason, you will be entitled to a prorated refund of your annual membership fee. Such prorated refund will be based on the number of days you have participated in the Program. Upon PERSONALIZED PRIMARY CARE'S receipt of this Agreement and the membership fee, PERSONALIZED PRIMARY CARE shall have the option, in its sole and absolute discretion, not to accept this Agreement and to return your payment to you (e.g., due to limitations on the number of Members).

4. **Medical Care Services Excluded from Annual Membership Fee.** The membership fees specified above cover only the defined PERSONALIZED PRIMARY CARE Amenities and the annual comprehensive physical examination and personalized preventive healthcare plan visit. Except for your physical examination and preventative visit, you and/or your insurer, as the case may be, will be financially responsible for paying for all healthcare and medical care services received by you from the physicians at PERSONALIZED PRIMARY CARE. As necessary, PERSONALIZED PRIMARY CARE will bill you and/or your insurer, as the case may be, for such other medical or health care services provided to you.

5. **Co-Payments and Deductibles.** The membership fee does not affect the co-payments, co-insurance or deductibles that you are required to pay pursuant to the terms of your health or other insurance coverage. You will be financially responsible for any co-payments, co-insurance or deductible amounts required by your insurer.

6. **Insurance Information.** Please provide your health insurance information in the box provided below.

INSURANCE INFORMATION
Insurance Policy Information (as printed on your I.D. card)

Please Provide a Copy of your Insurance Card Front and Back

Person Responsible for Account: _____
Last Name First Name Initial

Relationship to Member:_____ Date of Birth: _____/_____/_____

Social Security #:_____-_____-_____

Address (if different from member's) _____

City:_____ State:_____ Zip:_____

Phone: (_____) _____-_____

Person Responsible Employed by: _____Occupation:_____

Business Address: _____Business Phone :(_____) _____-_____

Insurance Company: _____

Contact #: _____ Group #: _____ Subscriber #: _____

7. **E-mail Communications; Privacy.** If you wish to send e-mail communications to and receive e-mail responses from PERSONALIZED PRIMARY CARE's physicians, staff, employees, agents and representatives, you should be aware that e-mail is not a secure medium for sending and receiving potentially sensitive personal health information. Although PERSONALIZED PRIMARY CARE will take steps to keep your communications with PERSONALIZED PRIMARY CARE and its physicians, staff, employees, agents and representatives, confidential and secure, the confidentiality of e-mail communications cannot be assured or guaranteed. You also acknowledge and understand that e-mail is not a good medium for urgent or time-sensitive communications. In the event a communication is time-sensitive, you must communicate with PERSONALIZED PRIMARY CARE's physicians by telephone or in person. You acknowledge and understand that, at the discretion of PERSONALIZED PRIMARY CARE and/or as required by law, your e-mail communications may become part of your permanent medical record.

8. **Consent.** You agree to complete and sign the Consent section below.

9. **Entire Agreement.** Each of the undersigned agrees to the terms of this Agreement, all of which are expressed herein. There are no promises or representations except as set forth herein.

10. **Notices.** Any communication required or permitted to be sent under this Membership Agreement shall be in writing and sent to the party to be so notified via certified mail, return receipt requested, or provided via hand delivery, to the addresses set forth herein. Any change in address shall be communicated in accordance with the provisions of this Section 9.

11. **Governing Law.** The validity, interpretation and performance of this Agreement shall be governed by the laws of the State of Florida without giving effect to the principles of comity or conflicts of laws thereof. Each party hereto agrees to submit to the personal jurisdiction and venue of the state and federal courts having jurisdiction over Orange County, Florida for the resolution of all disputes arising in connection with the interpretation, construction and enforcement of this Agreement, and hereby waives the claim or defense therein that such courts constitute an inconvenient or invalid forum.

12. **Amendments and Waivers.** This Agreement may only be revoked, altered, amended, or modified by the written agreement of both parties hereto. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

13. **Section Headings.** Any section, section title or caption contained in this agreement is for convenience only, and in no way defines, limits or describes the scope or intent of this Agreement or any of the provisions hereof.

14. **Invalid Provisions.** The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

15. **Counterparts.** This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which shall constitute a single Agreement.

CONSENT

BY SIGNING YOUR NAME BELOW, YOU AUTHORIZE:

(i) PERSONALIZED PRIMARY CARE, AND/OR ITS PHYSICIANS, STAFF, EMPLOYEES, AGENTS AND REPRESENTATIVES, TO SHARE YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION WITH OTHER TREATING PHYSICIANS, HOSPITALS, HEALTH CARE FACILITIES, AND LICENSED HEALTH CARE PRACTITIONERS FOR THE PURPOSE OF PERFORMING PERSONALIZED PRIMARY CARE'S OBLIGATIONS UNDER THE AGREEMENT; AND

(ii) PERSONALIZED PRIMARY CARE AND OR ITS PHYSICIANS, STAFF, EMPLOYEES, AGENTS AND REPRESENTATIVES, TO RELEASE ANY MENTAL HEALTH, SUBSTANCE ABUSE AND HIV/AIDS INFORMATION CONTAINED IN YOUR PERSONAL HEALTH INFORMATION, BUT ONLY IF PERSONALIZED PRIMARY CARE FIRST OBTAINS YOUR SEPARATE, WRITTEN CONSENT TO DO SO. ADDITIONALLY, AFTER RECEIVING YOUR CONSENT TO DO SO, PERSONALIZED PRIMARY CARE SHALL ONLY RELEASE SUCH MENTAL HEALTH, SUBSTANCE ABUSE AND HIV/AIDS INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PURPOSES.

(iii) PERSONALIZED PRIMARY CARE AND/OR ITS PHYSICIANS, STAFF, EMPLOYEES, AGENTS AND REPRESENTATIVES, TO SEND YOUR PERSONAL HEALTH INFORMATION TO YOU VIA E-MAIL TO THE E-MAIL ADDRESS LISTED BELOW.

PERSONALIZED PRIMARY CARE'S POLICIES AND PRACTICES GOVERNING IT'S USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION ARE AVAILABLE TO YOU UPON REQUEST, AND SUCH POLICIES AND PRACTICES MAY BE CHANGED AS NECESSARY BY PERSONALIZED PRIMARY CARE AS CONTAINED THEREIN. YOU MAY REQUEST THAT PERSONALIZED PRIMARY CARE RESTRICT THE USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION TO ONLY TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PURPOSES. YOU MAY REVOKE THIS CONSENT AT ANY TIME BY PROVIDING WRITTEN NOTICE TO PERSONALIZED PRIMARY CARE IN ACCORDANCE WITH SECTION 9 OF THIS AGREEMENT. HOWEVER, IF PERSONALIZED PRIMARY CARE HAS TAKEN ANY ACTION IN RELIANCE ON YOUR PREVIOUSLY UNREVOKED CONSENT (FOR EXAMPLE IF PERSONALIZED PRIMARY CARE HAD RELEASED YOUR PERSONAL HEALTH INFORMATION TO YOUR INSURANCE COMPANY AS PART OF A CLAIM FOR REIMBURSEMENT) YOUR REVOCATION OF THIS CONSENT SHALL NOT APPLY TO SUCH PREVIOUS ACTIONS TAKEN BY PERSONALIZED PRIMARY CARE.

Patient/Member's Signature: _____Date:_____

MEMBER INFORMATION

Please Provide a Copy of a Photo ID

Each of the undersigned Members acknowledges that he or she freely and voluntarily executed this Membership Agreement.

Patient Name:_____
Last Name First Name Initial

Address:_____Apt#: _____

City:_____State:_____Zip:_____

Age: _____ Date of Birth _____/_____/_____ Social Security#: _____-_____-_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email Address: _____

Patient Occupation: _____ Employed By: _____

Business Address: _____ Business Phone: (_____)_____-_____

Spouse Name:_____
Last Name First Name Initial

Age: _____ Date of Birth _____/_____/_____ Social Security#: _____-_____-_____

Spouse's Occupation: _____ Employed By: ____

Number of Children: _____ Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Phone: (_____)_____-_____

FOR INTERNAL USE

DATE ACCEPTED BY PERSONALIZED PRIMARY CARE_____

Dr. James Scelfo 602 Front Street Celebration, Florida 34747

Signature:_____ _____
(Effective Date)