



## *Instructions for Completing the Membership Paperwork*

### **Welcome To The SignatureMD Family for Personalized HealthCare**

Please review each of the following documents attached to this link:

- ❖ **Personalized Care Membership Agreement**
- ❖ **Schedule 1: Personalized Care Membership Agreement for Additional Family Members**
- ❖ **Exhibit A: Terms and Conditions of Service**
- ❖ **Exhibit B: Authorization for Release of Protected Health Information (HIPPA)**

Print each document and complete the requested information as follows:

- ❖ **Personalized Care Membership Agreement:** Please indicate your selection as to *Prepaid Annual* fee or *Quarterly Installment* fee. Also, indicate the appropriate box, if you will be adding one or more members to your Membership Agreement. If so, complete *Schedule 1*.
- ❖ **Schedule 1:** If an additional family member or members will be joining your membership, please complete for each family member. Otherwise, you may disregard this Schedule.
- ❖ **Exhibit B:** This *Authorization for Release of Information* is optional. You may choose to authorize SignatureMD to access your demographic information for internal use only and to insure compliance with the federal privacy law, referred to as HIPPA. Please sign and date. If you choose NOT to execute this authorization, write: **DECLINE** after Line 7, sign and date.

Please forward your completed **Membership Agreement\***, **Exhibit B** and **Schedule 1**, if applicable, to my office in any of the following ways:

- ◆ **Fax: (714) 213-8750**
- ◆ **Scan and Email: [gordon.gunnstaff@smdmd.com](mailto:gordon.gunnstaff@smdmd.com)**
- ◆ **Mail to my office at:**

Gordon Gunn, M.D.  
100 E. Valencia Mesa Dr., Suite #215  
Fullerton, CA 92835

\*If you are paying by check, please make check payable to: **Signature MD**

If you have any questions, I will be pleased to discuss them with you. You may contact me at my office: **714-912-2211**

Sincerely yours,

Gordon Gunn, M.D.

**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 Gunn Personalized Care, Inc., a California corporation, having an address of 100 E. Valencia Mesa Dr., Suite 215, Fullerton, CA 92835 (“**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 \$2300 (annually)	Individual \$2600 annual (\$650 per quarter)
Two (2) adult individuals \$4400 (annually)	Two (2) adult individuals \$5000 (\$1250 per quarter)
Third (3 <sup>rd</sup> ) additional adult individual \$1900 (annually)	Third (3 <sup>rd</sup> ) additional adult individual \$2200 (\$550 per quarter)

ADDITIONAL NOTES	
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- 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	<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover <input type="checkbox"/> AMEX	CARDHOLDER NAME	
CARD NUMBER		EXPIRATION	
		CC 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** \_\_\_\_\_ Gunn Personalized Care, Inc.  
 \_\_\_\_\_ (Signature)  
 \_\_\_\_\_ (Print Name) By: Gordon Gunn, MD, President

**SCHEDULE 1 TO PERSONALIZED CARE MEMBERSHIP AGREEMENT**

*Additional Program Members (Gunn Personalized Care, Inc.)*

Program Member from page 1. \_\_\_\_\_

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:				

## TERMS AND CONDITIONS OF SERVICE TO PERSONALIZED CARE MEMBERSHIP AGREEMENT

Version Dated as of August 15, 2014

### 1. BACKGROUND

Gunn Personalized Care, Inc. ("**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 Program Member certain enhancements and amenities to professional medical services to be rendered by Personalized Care Practice to Program Member, as further described in Schedule 1 to these Terms. Upon prior written notice to Program Member, Personalized Care Practice may add or modify the Program Services set forth in Schedule 1, as reasonably necessary, and subject to such additional fees and/or terms and conditions as may be reasonably necessary.
- b) Program Member acknowledges that the Program Services are services that are not covered services under any insurance contract to which Program Member may be a party, including, without limitation, Medicare, and are not reimbursable by Program Member's insurer, health plan or any governmental entity, including Medicare. Program Member agrees to bear sole financial responsibility for the Member Amenities Fee and agrees not to submit to Program Member's insurer, health plan or governmental entity any bill, invoice or claim for payment or reimbursement of such Member Amenities Fee.
- c) Personalized Care Practice or its designated affiliate will separately charge Program Member or Program Member's insurer, health plan or governmental entity for medical, clinical, diagnostic or therapeutic services rendered by Personalized Care Practice or its designated affiliate to Program Member, and Program Member may seek payment or reimbursement from Program Member's insurer or health plan for any such service to the extent covered by Program Member's insurer, health plan or governmental entity.
- d) Program Member understands, agrees and covenants that this Agreement is a service contract, and not a contract for insurance.

**3. DESIGNATED PHYSICIAN.** Personalized Care Practice designates Gordon Gunn, MD as "Designated Physician" to render medical services to Program Member(s) in accordance with the Membership Agreement and these Terms. Program Member understands and acknowledges 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 Program Member's medical history and course of care to attend to Program Member's 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, the Agreement will not automatically renew if the Program Member is not current in all their financial obligations to Personalized Care Practice.

**5. MEMBERSHIP FEE.** Program Member agrees 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, the Program Member will be billed for the Member Amenities Fee for each Renewal Year prior to the beginning of each Renewal Year, and the Program Member agrees 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, Program Member agrees 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, Program Member authorizes the Personalized Care Practice and its staff and designees to communicate with Program Member by Electronic Communication regarding Program Member's personal health information (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations; "PHI") at Program Member's 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) Program Member acknowledges and agrees 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 Program Member, the Personalized Care Practice and Practice's designee(s) (and their employees, agents and representatives) confidential and secure, Program Member understands 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 Program Member's permanent medical record; and
  - iv. Electronic Communication is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information.
- c) Program Member further acknowledges and agrees that:
  - i. Program Member will not use Electronic Communication for communications regarding emergencies or other time-sensitive issues, or for communication regarding sensitive information;
  - ii. If Program Member does not receive a response to Program Member's Electronic Communication message within one (1) business day (or such longer time as Program Member indicates in the Electronic Communication), Program Member will use another means of communication to contact Personalized Care Practice or appropriate representative;
  - iii. Program Member will include Program Member's full name and a short description of the subject matter of the Electronic Communication (e.g., "prescription refill", "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, Program Member 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 Program Member for any loss, damage, cost, injury or expense caused by, or resulting from: (i) a delay in response to Program Member 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) Program Member's failure to comply with the guidelines regarding use of Electronic Communication set forth in this Section 6.

### 7. TERMINATION

- a) Program Member may terminate this Agreement at any time upon thirty days prior written notice to Personalized Care Practice and Signature MD. Program Member 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 Program Member's breach of this Agreement if such breach is not cured within 10 days; or (ii) 30 days prior written notice to Program Member, with or without cause, related to the patient-physician relationship or any other non-contract related issue; provided, however, that Program Member will be entitled to a refund of a prorated portion of the Member Amenities Fee paid by Program Member 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 Program Member's 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 Program Member with respect to medical services rendered to Program Member, 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 Program Member and Program Member's 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 CALIFORNIA, 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 PROGRAM MEMBER AND PERSONALIZED CARE PRACTICE OR THEIR RESPECTIVE AFFILIATES AND AGENTS ARISING UNDER OR RELATING TO THIS AGREEMENT SHALL BE RESOLVED EXCLUSIVELY BY ARBITRATION IN ORANGE COUNTY IN THE STATE OF CALIFORNIA, BEFORE A NEUTRAL ARBITRATOR, under the auspices of the American Arbitration Association, 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 Program Member 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 the Program Member 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.** Program Member may not assign the Agreement. Personalized Care Practice shall have the right to assign this Agreement 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 the Program Member 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 <sup>1</sup>**

- 1. Digestive Health; Vitamins & Dietary Supplements Counseling.** Personalized Care members will have the option to receive advice about digestive health, vitamins and other dietary supplements and will get assistance in preparing a plan to incorporate vitamins and dietary supplements into their therapy and daily routine designed to improve their health and well-being.
- 2. Comprehensive Genetic Counseling.** Personalized Care Program members will have the option to be advised and counseled regarding preventive genetic therapy. This includes diagnostic and supportive aspects, such as comprehensive discussions and counseling regarding the existence, consequences and nature of genetic conditions, potential disorders and the probability of developing or transmitting it, and the options open in management and family planning.
- 3. 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.
- 4. Enhanced Appointment Scheduling Options.** Same-day and next-day appointments that are medically necessary in the Designated Physicians professional judgment are covered by Program Member's 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, Program Member is entitled to enhanced options for scheduling of appointments for any medical care. 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 Program Member will be made within a business day and a plan will be made between them for any further follow-up necessary.
- 5. Communication Enhancements.** Program Members 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.")
- 6. Prompt Availability.** Designated Physician's or, when applicable, a covering physician's urgent and unscheduled availability that is medically necessary is covered by Program Member's health plan, is not part of this Membership Agreement and payment of Program Fees is not a condition of receipt of such medical services by any patient. When not medically necessary, arrangements will be made for Designated Physician or, in Designated Physician's absence, Personalized Care Practice's other designee, to be available promptly to personally communicate with Program Member, at all times to a reasonable extent, through telephone or telephone call enhancements. The response time and the method of communication will be appropriate to the purpose of the communications. **If the matter is possibly life threatening, 911 should be contacted first and then, if possible, call the Personalized Care Practice.**
- 7. 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 Program Member can ask additional questions relating to Program Enhancements and Amenities, discuss health goals and formulate a plan to achieve such goals.
- 8. Personal Administrative Assistant.** A representative of Personalized Care Practice will be dedicated to Program Member to assist addressing and coordinating the administrative aspects of the Personalized Care Practice and Program Services.
- 9. Comprehensive Health Planning.** Arrangements will be made for Personalized Care Practice to provide periodic health planning assessments to Program Member in addition to the annual physical examination that is generally covered by health plans, to set Program Member's health goals and to evaluate progress in achieving those goals. The parameters of this periodic health assessment will include only items that are not covered by Program Member's 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 Program Member to address environmental and other obstacles to health improvement and wellbeing.
- 10. Office Amenities.** Program Member will have access to a semi-private waiting area that includes member amenities.
- 11. Personalized Health Education.** Arrangements will be made to provide Program Member with regular personalized health information on topics pertinent to Program Member's 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 web posting or e-mail. Arrangements may also be made to arrange for Program Member to attend education, lecture, support group and discussion sessions, at Program Member's choice. (Additional registration fees may apply for such sessions.)

<sup>1</sup> 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 the Program Member's health plan only for covered medical services.

**EXHIBIT B**

**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, my health or my health care that is maintained by Gunn Personalized Care, Inc. (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 concierge medical 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.

Acknowledged and agreed:

<i>1. Print Patient's Name</i>	<i>Signature of Patient or Patient's Representative</i>	<i>Date</i>
<i>2. Print Patient's Name</i>	<i>Signature of Patient or Patient's Representative</i>	<i>Date</i>
<i>3. Print Patient's Name</i>	<i>Signature of Patient or Patient's Representative</i>	<i>Date</i>
<i>4. Print Patient's Name</i>	<i>Signature of Patient or Patient's Representative</i>	<i>Date</i>
<i>Gordon Gunn, MD</i>	<i>Date</i>	

***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)*