LONGEVITI.HEALTH
MODERN HEALTHCARE | SIMPLIFIED

CONCIERGE / PERSONALIZED CARE MEMBERSHIP AGREEMENT

("Membership Agreement")

This Membership Agreement is made as of _____, 20_____ by and between the undersigned member and, if applicable, the additional members listed on Schedule I, (each a "Member" or "PC Program Member"), and **PJB Personalized Medical Care, PLLC**, the concierge / personalized care program (the "PC Program"), located at **110 E 59th Street, Suite 9A, New York, New York 10022**, and specifies the terms and conditions under which Member will be enrolled in the PC Program. In this Membership Agreement, PC Program includes, without limitation, the physician(s), staff, employees, agents and representatives of PC Program, and Member and PC Program may each be referred to as a Party and together as the Parties.

In consideration of payment of the PC Program Membership Fee (defined below in Section 3) by Member to PC Program, the Parties agree as follows:

1. TERMS OF SERVICE. The Parties agree to fully comply with the terms and conditions ("T&Cs") attached hereto as Exhibit C which are incorporated herein and made a part of this Membership Agreement by reference.

2. MEMBER INFORMATION; ADDITIONAL MEMBERS. PC Program Member represents and warrants that the information set forth below, as well as the information for any additional PC Program Members as may be set forth in Schedule 1, is accurate and complete. Member agrees to promptly notify PC Program of any changes to such information in writing.

3. PC PROGRAM MEMBERSHIP FEE. The current Annual Membership Fee for the PC Program is as follows:

Please check the appropriate boxes below for billing status and frequency.

☐ **INDIVIDUAL ADULT: $5,000.00** ☐ **ADULT COUPLE: $10,000.00**

☐ **MONTHLY** ☐ **QUARTERLY** ☐ **SEMI-ANNUALLY** ☐ **ANNUALLY (10% DISCOUNT)**

NOTE: Minor children should not be listed as Members under this Agreement. Your physician (Peter J Bruno, MD) may, at his discretion, agree to see minor children depending upon his availability.

MEMBER INFORMATION

Please Provide a Copy of a Photo ID

The undersigned acknowledges that he/she freely and voluntarily executed this Membership Agreement.

Last Name:_____ First Name:_____ Initial:_____

Date of Birth:_____ Signature of Member:_____ Date:_____

Address:_____

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

Email: _____

SCHEDULE I

ADDITIONAL MEMBERS

Print Member Name	Date of Birth	Signature of Member or Representative	Date
Print Member Name	Date of Birth	Signature of Member or Representative	Date
Print Member Name	Date of Birth	Signature of Member or Representative	Date
Print Member Name	Date of Birth	Signature of Member or Representative	Date

NOTE: You may change your status as an individual or couple at any time and you may add or remove additional Members. You may not transfer your membership to any other individuals.

FOR INTERNAL USE ONLY **ACCEPTED BY: PJB Personalized Medical Care, PLLC**

DR. PETER J BRUNO

SIGNATURE:_____ **DATE:**_____

FOR ALL PC PROGRAM MEMBERSHIP FEE PAYMENTS:

CASH, CHECK, ACH AND CREDIT / DEBIT CARD PAYMENTS WILL BE PROCESSED BY LONGEVITI HEALTH, LLC ("LONGEVITI") WITH WHOM PC PROGRAM HAS A SEPARATE AGREEMENT FOR THE IMPLEMENTATION OF THE PC PROGRAM CONCIERGE / PERSONALIZED CARE PROGRAM AS WELL AS THE BILLING AND ACCOUNTING OF PC PROGRAM MEMBERSHIP FEES. ACCORDINGLY, MEMBER SHALL MAKE ALL MEMBERSHIP FEE PAYMENTS, WHETHER BY CHECK, ACH OR CREDIT / DEBIT CARD, PAYABLE TO LONGEVITI.

CHECKS SHOULD BE MADE OUT TO LONGEVITI HEALTH, LLC AND MAILED TO:

LONGEVITI HEALTH, LLC
2645 EXECUTIVE PARK DRIVE
WESTON, FL 33331

FOR QUESTIONS PLEASE CALL: 1- 888-580-6170

VISIT US AT: www.longeviti.health

EXHIBIT A

RECURRING MEMBERSHIP FEE PAYMENT OPTIONS

Payment must be included with signed Membership Agreement

Please complete the information below:

I,_____**,** ***(FULL NAME AS IT APPEARS ON YOUR CARD / BANK ACCOUNT)***
do hereby authorize LONGEVITI HEALTH, LLC to charge/debit my account as indicated below:

Please check the appropriate billing frequency box below.

☐ **MONTHLY** ☐ **QUARTERLY** ☐ **SEMI-ANNUALLY** ☐ **ANNUALLY (10% DISCOUNT)**

All recurring Annual Payments for PC Program Membership Fees will be debited/charged on the **first day of the month immediately preceding the anniversary date of your Membership Agreement.**

All recurring Monthly, Quarterly, or Semi-Annual installment payments for PC Program Membership Fees will be debited/charged on the **first day of the month immediately preceding the next billing installment period as selected above.**

Billing Address: _____ Phone #: _____

City, State, Zip: _____ Email: _____

Checking / Savings Account

☐ **Checking** ☐ **Savings**

Name on Account: _____

Bank Name: _____

Account Number: _____

Bank Routing #: _____

Bank City/State: _____

Credit / Debit Card

☐ **Visa** ☐ **MasterCard**
☐ **Amex** ☐ **Discover**

Cardholder Name: _____

Account Number: _____

Exp. Date: _____

CVV (3-digit number on back of Visa / MC / Discover): _____

Security Code (4-digit number on front of AMEX): _____

CARD / ACCOUNT HOLDER SIGNATURE: _____ **DATE:** _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Longeviti Health, LLC in writing of any changes in my account information or termination of this authorization at least fifteen (15) days prior to the next billing date. If the above-noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above-noted periodic transaction dates. In the case an ACH transaction is rejected for Non-Sufficient Funds (NSF), I understand that Longeviti Health, LLC may, at its discretion, attempt to process the charge again within thirty (30) days, and agree to an additional $50.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute the scheduled transactions with my bank or credit card company provided the transactions correspond to the terms indicated in this authorization form.

EXHIBIT B

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

By my signature below, I hereby consent to and direct the use and/or disclosure of certain Protected Health Information ("PHI") (as such term is defined by HIPAA) pertaining to me, my health and/or my health care that is maintained by PC Program. I understand that I have the right to revoke this consent in writing and acknowledge that any such revocation will not be retroactive in the event that PC Program has previously disclosed my PHI in reliance on this Consent.

1. This Consent concerns the following medical information about me: demographic information including but not limited to name, age, address, phone number, email address, health status, and name of insurance company.

2. PHI may be used or disclosed by PC Program to Longeviti Health, LLC, with which PC Program maintains a Business Associate Agreement ("BAA") as such term is defined by HIPAA.

3. This Consent expires immediately upon termination of my PC Program Membership Agreement.

4. The purpose of the use or disclosure of my PHI is made at my request in order to facilitate the administration of the PC Program services to and for me by PC Program.

5. I understand and acknowledge that once such information is disclosed by PC Program, PC Program no longer controls such information.

6. I understand that PC Program is prohibited from requiring that I sign this Consent a condition of my enrollment of eligibility for benefits except for specific exceptions which are not applicable here.

This Consent was signed by:

_____	_____	_____
Print Member Name	*Signature of Member or Member's Representative*	*Date*
_____	_____	_____
Print Member Name	*Signature of Member or Member's Representative*	*Date*
_____	_____	_____
Print Member Name	*Signature of Member or Member's Representative*	*Date*
_____	_____	_____
Print Member Name	*Signature of Member or Member's Representative*	*Date*
_____	_____	_____
Print Member Name	*Signature of Member or Member's Representative*	*Date*

If by and through a representative of a PC Program Member:

My authority to sign this Consent and agree to the terms herein exists because I am:

☐ **Parent (of minor child)** ☐ **Legal Guardian** ☐ **Durable Power of Attorney**

(Check box above that describes your relationship to Member, or source of authority to sign on Member's behalf)