Dr. Chris LeBlanc
VITAL
Personalized Healthcare

Dr. Chris LeBlanc, DO
23 Plantation Park Drive,
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29910
843-815-5566

VITAL Personalized Healthcare, LLC, offers our patients ("Patient," "you," or "your"), the opportunity to participate in our direct private primary care medical practice program ("Program"). This Program agreement ("Agreement") specifies the terms and conditions under which you may participate in VITAL Personalized Healthcare's Program. (VITAL Personalized Healthcare and Patients are each individually referred to as "Party" or collectively as "Parties").

I Program

VITAL Personalized Healthcare limits the number of participating patients to revolutionize your wellbeing and primary healthcare experience. As part of this vision, VITAL Personalized Healthcare offers the following additional amenities in exchange for your payment of the annual Program participation fee described below:

- Comprehensive personalized routine annual physical, regardless of your medical condition (for our Medicare covered Patients, this physical is in addition to the one time initial "Welcome to Medicare Exam," and Medicare's Annual Wellness Visit).
- Enhanced connection with providers via 7-day-a-week telephone and electronic connection to assist with implementing your annual physical wellness goals.
- Convenient scheduling via same-day or next-day appointment arrangements.
- Visits that are not rushed by health plan constraints so that you will receive the personalized time and attention you deserve.
- Prompt appointment start times because your time is valuable.
- House calls when needed (your participation fees cover the provider's travel costs)

II Annual Participation Fee:

The annual participation fee for the Program is $1950.00 per Patient each year ("Annual Fee"). The Annual Fee provides you with additional amenities and benefits not covered by health plans and/or Medicare. Participating Patients must pay their initial Annual Fee by the Agreement date listed below. All subsequent Annual Fees are due on the anniversary of the Agreement date, unless prior alternate arrangements have been made in writing with VITAL Personalized Healthcare.

Patients may choose to pay annually or semi-annually. If you pay the Annual Fee in one payment, a 10% discount will apply ($1755.00). We also offer our Patients the option of paying the Annual Fee in two payments of $975.00 ("Semi-Annual Fee"). The Annual fee for couples is $3900.00, and if you pay the Annual Fee in one payment, a 10% discount also applies ($3510.00). Semi Annual couples fee is $1950.00. We also offer monthly and quarterly billing, by credit card only. This will be a recurring payment. The price for single monthly is $162.50, couples monthly is $325.00, single quarterly is $487.50 and couples quarterly is $975.00.

III Renewals and Termination:
Your Annual Fee covers your participation in VITAL Personalized Healthcare's Program for a period of one (1) year. Failure to pay Annual Fee renewals before the expiration of the prior year period may result in termination of your participation in the Program. Either Party may terminate this Agreement for any reason with thirty (30) days prior written notice. In addition, VITAL Personalized Healthcare may terminate this Agreement at any time if the Patient fails to pay the Annual Fee within the specified time period. Upon termination of this Agreement, you may request a refund of any unused pro-rata portion of their Annual Fee, minus any fees that have been substantially earned with the delivery of the annual routine physical.

IV Insurance:
You acknowledge that this Agreement is not a substitute for health insurance (including Medicare). If you chose not to maintain health insurance, this may result in tax penalties and other consequences under applicable law and leave you without health insurance to cover more significant health needs. We have advised you to retain or secure health insurance, as our Program is not an insurance plan.

V Agreement Effective Date and Governing Law:
Your participation in the Program is complete with the execution of this Agreement and VITAL Personalized Healthcare's receipt of your Annual Fee. This Agreement replaces and supersedes all prior agreements between Parties and may not be modified absent a writing signed by both you and Dr. Christopher LeBlanc as the authorized representative of VITAL Personalized Healthcare. This Agreement is governed by South Carolina state laws, without application of choice-of-law principles. Your signature on this Agreement represents that you understand and accept the terms of participation described above.

VITAL Personalized Healthcare, LLC
A South Carolina limited liability company

Signature

_____

By: **Dr. Christopher LeBlanc, D.O.**

Title:

Agreement Date:

Patient

Signature_____

Printed Patient Name_____

Agreement Date_____

Patient

Signature_____

Printed Patient Name_____

Relationship to Patient_____

Agreement Date_____

VITAL PERSONALIZED HEALTHCARE ELECTRONIC COMMUNICATIONS AGREEMENT

VITAL Personalized Healthcare, LLC, and our patient ("Patient," "you," or "your") enter into this electronic communications Agreement ("EC Agreement") regarding the use of various versions of electronic communications, such as e-mail, mobile or cellular telephone, text messaging, Skype, FaceTime, internet portal-enabled communications, or any other version of electronic communication (collectively "E-communication"). (VITAL Personalized Healthcare and Patients are each individually referred to as "Party" or collectively as "Parties").

Patient Authorization Despite Risks of Privacy Breach

You authorize E-communication for communication between the Parties. These communications may include references to Patient's Personal Health Information ("PHI") with sensitive health and personal identification information. You acknowledge that E-communication lacks any guaranty of privacy, and are subject to: system privacy failure, cookies and other tracking efforts, phishing attacks, hack attacks, data breach, unintended misdirection, or misidentification of senders/recipients, technology failure, and user error. VITAL Personalized Healthcare and Patient must both engage in good faith reasonable efforts to protect Patient privacy, but utilization of E-communication is inherently risky and prone to unintentional release of data. You authorize VITAL Personalized Healthcare to respond electronically to all E-communications that appear to be provided from you, whether or not such communications actually arrive from the electronic contact information you provide to us.

Patient Must Provide Accurate & Updated Contact Information

You agree to provide Vital Personalized Healthcare with your accurate E-communication contact information (mobile telephone number, email address, Skype, or FaceTime contact information, and any other applicable E-communication contact information). You shall immediately inform VITAL Personalized Healthcare of any changes or corrections to your E-communication contact information.

Patient Must Not Rely on E-Communication to Vital Personalized Healthcare in Emergencies: Use 911 and Get to the Emergency Room

You agree not to utilize E-communications to contact VITAL Personalized Healthcare regarding an immediate emergency or time-sensitive situation, as there is too much risk that the communication response may be delayed, ineffective, untimely, or inadequate. Patient MUST call 9-1-1 in any emergency situation, and/or must immediately seek emergency medical attention.

VITAL Personalized Healthcare Shall Comply With HIPAA

VITAL Personalized Healthcare values your privacy and will take commercially reasonable steps to protect your privacy in compliance with HIPAA.

VITAL Personalized Healthcare will obtain your express written or electronic consent (to the extent required by applicable law) if we are required or requested to forward your identifiable PHI to any third party other than as authorized in our Notice of Privacy Practices or as authorized or mandated by applicable law.

You consent to the use of E-communication of your information, as deemed helpful by us, to coordinate care and achieve scheduling with you and all parties responsible for providing or overseeing your care. You agree to identify individuals or entities authorized to receive Patient PHI from VITAL Personalized Healthcare in connection with authorized consulting, education, and all other aspects of supporting your care, and we may share your PHI with such parties without additional written or electronic consent from your and/or Patient.

You have the right to request from us a copy of your PHI, including an explanation or summary.
The following services performed by us shall not be the subject of additional charges to you: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information.

Your fees charged to you for requesting electronic PHI may include: skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning and burning PHI to media and distributing the media with media costs charged to you; and our administrative staff time spent preparing additional explanations or summaries of PHI.

If you request that your PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), our actual supply costs for such equipment may be charged to you and you agree to pay VITAL Personalized Healthcare such costs.

Patient Accepts Responsibility for E-Communication Risks
You agree to hold harmless VITAL Personalized Healthcare and its owners, officers, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or related to or caused by: a) E-communication by VITAL Personalized Healthcare (whether encrypted or not); b) losses or disclosures caused by any of the E-communication risks identified in this EC Agreement; and c) losses or disclosures caused by some person or entity other than us, or, not directly and solely caused by us. You acknowledge and understand that, at our discretion, E-communication may or may not become part of your permanent medical record.

You acknowledge that your failure to comply with the terms of this EC Agreement may result in Vital Personalized Healthcare terminating the use of E-communication with you and may result in the termination of your underlying physician-patient agreement.

Acknowledgment of Receipt of Notice of Privacy Practices:
VITAL Personalized Healthcare is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. You hereby acknowledge receipt of the Notice.

Additional EC Agreement Terms:
This EC Agreement will remain in effect until either Party provides written notice to the other Party revoking this EC Agreement or otherwise revoking consent to E-communications between the Parties, and such revocation will occur thirty (30) calendar days after written notice of such revocation.

Revocation of this EC Agreement will preclude VITAL Personalized Healthcare from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by the Patient.

Either Party may use a photocopy or digital copy of the signed original EC Agreement for all present and future purposes. Each participating patient over the age of 21 is required to sign this EC Agreement.

Your signature represents that you understand and agree to the terms and conditions described within this EC Agreement.

The annual participation fee for the Program is $1950.00 per Patient each year ("Annual Fee").

VITAL Personalized Healthcare, LLC
A South Carolina limited Liability company

Signature _____

By: **Dr Christopher LeBlanc, D.O.**

Title:

Agreement Date :

Patient

Signature _____

Printed Name _____

Agreement Date _____

Patient

Signature _____

Printed Name _____

Agreement Date _____

Dr. Chris LeBlanc
VITAL
Personalized Healthcare

Member Information:

Member Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Email:_____

Family Members: (children are included with one adult membership: ages 10 to 26)

Name:_____ Age:____

Date of Birth:_____

Name:_____ Age:____

Date of Birth:_____

Name:_____ Age:____

Date of Birth:_____

Initial Term: This Agreement is executed as of, and the Initial Term shall expire on the following dates:

Effective Date: _____Expiration Date:_____

I desire to pay:

Monthly and Quarterly Billing - By Credit Card Only (Will be Recurring Payments)

Single Monthly:_____$162.50 Couples Monthly:_____$325.00 Single Quarterly:_____$487.50

Couples Quarterly:_____$975.00

Semi-Annual and Annual Billing - By Check or Credit Card

Single Semi Annual:___$975.00 Couples Semi-Annual:___$1950.00 Single Annual:____$1755.00

Couple Annual:_____$3510.00

By Check:#_____$_____(Vital Personalized Healthcare)

Payment Authorization: By signing below, Member authorizes VITAL Personalized Healthcare to charge Members credit card set forth below for the annual fee as and when due hereunder.

Name as it appears on the Credit Card:_____

Billing Address if not the same as above:_____

City:_____ State:_____

ZIP:_____

Card #:_____

Exp. Date:_____ CVV Code:_____

IN WITNESS WHEREOF, the Parties have executed and delivered Patient Membership Agreement as of the date shown below.

Member:

Signature:_____

Print:_____

Date:_____

Provider:

Signature:_____

Print:_____

Date:_____