DANIEL GAITAN
PERSONALIZED HEALTHCARE

APPLICATION TO PARTICIPATE
IN PERSONALIZED SERVICES PROGRAM

Primary Applicant Information **Date: _____**

Full Legal Name:	
Date of Birth:	
E-Mail Address:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Fax Number:	
Street Address:	
City:	
State:	
Zip Code:	

Secondary Applicant Please see Terms and Conditions section 8 for secondary member criteria.

Name:	
Date of Birth:	
E-Mail Address:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Fax Number:	
Street Address:	
City:	
State:	
Zip Code:	

Tertiary Applicant Please see Terms and Conditions section 8 for tertiary member criteria.

Name:	
Date of Birth:	
E-Mail Address:	
Home Phone:	
Mobile Phone:	
Work Phone:	
Fax Number:	
Street Address:	
City:	
State:	
Zip Code:	

Payment Information:

☐ Pay by Credit Card

Name on Card: _____

Credit Card Type: _____

Credit Card No.: _____

Expiration Date: _____

Security Code: _____

Billing Zip Code: _____

* Keep Card on File for Automatic Billing YES NO (Circle One)

☐ Pay by Debit Card

Name on Card: _____

Debit Card Type: _____

Debit Card No.: _____ Security Code: _____

Expiration Date: _____

☐ Pay by Check Payable to **Daniel Gaitan Personalized Healthcare, LLC**

Payment Plan All contracts are for a 12 month term

☐ Annual Payment **(Payable upon Application)**

- ☐ $2,000 per year for Primary Applicant
- ☐ $1,800 per year for Secondary Applicant
- ☐ $1,800 per year for each Tertiary Applicant

* **Primary Applicant is responsible to pay for the Primary Applicant, the Secondary Applicant and Each Tertiary Applicant.**

Please initial boxes below

☐ I have been provided with and understand the Terms and Conditions for Daniel Gaitan Healthcare, Inc.

☐ I have been provided with the HIPAA Notice of Privacy Practice by Daniel Gaitan Healthcare, Inc.

Each of the undersigned Applicants applies to participate in the Personalized Services Program (the "Program") offered by Daniel Gaitan Personalized Healthcare, LLC ("Program Sponsor"), as described in the Terms and Conditions of Personalized Services Program attached to this Application (the "Terms and Conditions").

If an Applicant is accepted by Program Sponsor to participate in the Program (as signified by the signature of the Executive Director of the Program Sponsor at the end of this Application), the Applicant shall become a participant in the Program (a "Participant"), as outlined in the Terms and Conditions, and Applicant's participation in the Program will be subject to and bound by and Applicant will comply with the Terms and Conditions.

In consideration of being accepted as a Participant in the Program, Applicant agrees to pay to Program Sponsor the amounts listed above at the times listed above in the manner listed above and if indicated above, authorizes Program Sponsor to credit/debit his/her credit card/debit card to pay such amount.

In consideration for such payment, Program Sponsor agrees to provide each Applicant with Personalized Services under the Program as described in and subject to the Terms and Conditions.

[SIGNATURE PAGE FOLLOWS]

THIS CONTRACT CONTAINS AN ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

Acceptance by Program Sponsor or Representative

*** Primary Applicant Signature and Date**

By:_____
Melissa Frazier-Gaitan, MSN, APRN, FNP-BC
Family Nurse Practitioner and Executive Director

*** Secondary Applicant Signature and Date**

Date of Execution: _____

Address: 425 North New Ballas Road, Suite 107
St. Louis, MO 63141

*** Tertiary Applicant Signature and Date**
(if 18 years or older and under 26)

* ALL PARTICIPATING PARTIES MUST SIGN CONTRACT *